

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00142052.</p> <p>Complaint IN00142052-Substantiated, Federal/State Deficiency related to the allegations is cited at F-241.</p> <p>Survey Dates: January 9 & 10, 2014.</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type: Medicare: 15 Medicaid: 70 Other: 28 Total: 113</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/10/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000241 SS=E	<p>Sample: 3</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 13, 2014 by Randy Fry RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure staff used washcloths instead of rags for resident care for 4 of 10 residents interviewed.</p> <p>Finding includes:</p> <p>Confidential interviews with direct care staff during the survey from 1/9/14 through 1/10/14, indicated 7 of 14 staff members indicated they had used "rags" (towels that had been cut into rags to use to clean up spills) to wash residents. Staff</p>	F000241	<p>1. Facility reviewed all linen supply closets to ensure facility had enough washcloths and that 'rags' are not available for use.</p> <p>2. Facility will perform random staff and resident interviews to ensure no 'rags' are used with patient care. 3. . Locks have been put on the linen closets to deter any residents or family members from taking excessive amounts of linen. Locks were also put on the laundry doors to ensure that staff do not take housekeeping 'rags' at any time. Employees are being in-serviced and reminded that Housekeeping Supervisor and Executive Director's cell phones numbers are posted throughout the facility and need to be notified if staff</p>	02/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated they would run out of washcloths and use the rags to provide care to residents. Staff indicated the following:</p> <p>Staff #1-Often have to go to the laundry to get washcloths. Sometimes there are no washcloths. Have used rags to provide care.</p> <p>Staff #2-Have used rags because that is all they have. Laundry has even put them in the linen closet.</p> <p>Staff #5-No washcloths first thing in the morning. This happens at least once a week when there are no washcloths, and I have to use the rags.</p> <p>Staff #7-I work first and sometimes second shift. Washcloths are a problem. I have had to use the rags because that is all I had.</p> <p>Staff #11-The facility is short of washcloths and towels. I call the laundry to get more and sometimes they do not have any. This happens almost every day. I have even used</p>		<p>have concerns with linen at any time. ED or designee will interview three staff members or residents weekly for a month to ensure 'rags' are not being used while providing care. ED or designee will conduct random observations three days a week for one month, then two days a week for a month and then monthly for three months. 4. Audits will be reviewed by Executive Director monthly and by the Medical Director quarterly in QA meetings for six months. 5. Alleged Compliance: February 3, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a pillow case.</p> <p>Staff #13-We are short of washcloths and towels. I do not know what the problem is and I have used towels that have been cut up and are used for rags.</p> <p>Staff #14-We are short hand towels and washcloths. One night the laundry aide put out rags in the linen closet.</p> <p>During the survey from 1/9/14 through 1/10/14, 4 of 10 residents interviewed indicated they had a concern with the facility being short of washcloths and towels. The residents stated the staff used "rags" when they were short and it bothered them. Interview with resident #1 on 1/10/14 at 2:00 p.m. indicated she did not get a shower last week because there were no towels and indicated it happened again last night.</p> <p>Interview with the laundry aide on 1/9/14 at 2:40 p.m. indicated staff have come to the laundry and taken</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the rags but she does not know if they used them for resident care.</p> <p>Interview with the Administrator and Environmental Services Director on 1/9/14 at 11:00 a.m. indicated they knew there was a problem with wash cloths and felt the staff may be throwing them away and also indicated some residents were hoarding them in their rooms. They indicated they have gone to "clear trash bags" so they can see if they are being thrown away and are going to put locks on the linen doors so residents cannot get into the room.</p> <p>On 1/9/13 at 2:30 p.m. the Administrator presented the writer with the invoices from 10/7/13 through 12/23/13 for linens. Review of the invoices indicated the facility had ordered 180 dozen washcloths during this time period.</p> <p>This federal tag relates to complaint IN00142052.</p> <p>3.1-3(t)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE