

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  11/13/2014
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NAME OF PROVIDER OR SUPPLIER  COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F000000	<p>This visit was for the Investigation of Complaint IN00158649.</p> <p>Complaint IN00158649 – Substantiated, Federal/State deficiency is cited at F327.</p> <p>Survey Dates: November 7, 12 &amp; 13, 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: 114 Total: 114</p> <p>Census payor type: Medicare: 23 Medicaid: 66 Other: 25 Total: 114</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2–3.1.</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and 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.

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F000327 SS=D	<p>Quality review completed on November 14, 2014 by Randy Fry RN.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview the facility failed to monitor and document fluid intake for 1 resident (B) who was treated at the hospital for dehydration in a sample of 3 resident records reviewed.</p> <p>Findings include:</p> <p>On 11/12/14 at 10:30 a.m. review of the clinical record for resident (B) indicated he was admitted to the facility on 9/5/14 with Diagnoses including but not limited to Dementia, Muscle Atrophy, Hypertension and Osteoarthritis.</p> <p>Review of nursing notes on 11/13/14 at 9:45 a.m. indicated the following:</p>	F000327	<p>1. Resident "B" no longer resides at the facility. 2. Residents that have consumed only 50% of their meals including fluids in the past 7 days will be reviewed for signs and symptoms of dehydration. If residents are found to have signs and symptoms of dehydration, staff to encourage fluids. No other residents were found to be affected by this deficient practice. 3. Residents that eat less than 50% of their meals the previous day will be assessed for dehydration. If a resident upon assessment shows sign and symptoms for dehydration, interventions will be implemented as appropriate. Staff will be educated on signs and symptoms of dehydration. 4. Meal consumption, which includes fluid intake, will be monitored by DON or designee 5 days/week for 1 month, then weekly for 1 month</p>	12/12/2014

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	<p>9/25/14 at 12:09 p.m. – "Writer called into resident's room related to increased lethargy and decreased level of consciousness and slurred speech. Writer did head to toe assessment. Blood pressure 122/78, pulse 78, respirations 16, temperature 98.8, grip strength greater on the right than on the left. Able to follow simple commands intermittently. Nurse Practitioner notified. No new orders at this time."</p> <p>9/25/14 12:29 p.m. – "Nurse in to assess patient."</p> <p>9/25/14 12:40 p.m. – Nurse Practitioner notified of resident's decreased level of consciousness and increased lethargy. Confusion increased and resident refusing to eat. Blood glucose level obtained and it is 107."</p> <p>9/25/14 at 12:30 p.m. – "Director of Nursing notified and order to transfer patient to emergency room received."</p> <p>On 11/13/14 at 10:45 a.m. review of the emergency room notes for resident (B) dated 9/25/14 at 1:33 p.m. indicated the resident was</p>		<p>and monthly for 4 months. Results will be reviewed at QA monthly and reviewed by the MD on a quarterly basis.</p>		

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	<p>assessed, and his mucous membranes were dry. The progress note indicated "Had several interactions with the patient and he did awake alert and appropriate. His workup shows nothing acutely although his abdomen [sic] is slightly elevated. We'll give him fluids he is thirsty and wants to drink. He was discussed with his physician. We will return him to his nursing home."</p> <p>Review of the Emergency Room Laboratory results indicated the resident's Blood Urea Nitrogen was high at 32 mg/dl (milligrams per deciliter) normal limit is 6 to 20. His Creatinine was high at 1.8 mg/dl, normal limit is 0.9 to 1.3. Review of medication orders for this resident indicated he was given 1000 milliliters of Sodium Chloride per intravenous route for a diagnosis of dehydration and was discharged back to the nursing home on 9/25/14 at 3:49 p.m.</p> <p>Review of resident (B'S) clinical record on 11/13/14 at 11:30 a.m. indicated a "Nutrition Screening and Assessment" dated 9/10/14 which indicated the residents daily fluid needs were 2324 to 2490</p>				

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	<p>milliliters daily.</p> <p>On 11/13/14 at 10:00 a.m. interview with CNA (certified nursing assistant) #1 indicated the staff do not monitor the amount of fluids residents consume. CNA #1 indicated they push fluids if the nurses tell them a resident needs more fluids but they do not record how much fluids the residents consume.</p> <p>Interview with the Director of Nursing (DON) on 11/13/14 at 11:50 a.m. indicated the facility did not have a hydration policy. The DON indicated the the CNA'S document the percentage of a meal residents consume into the "AccuNurse/Vocollect" System, but indicated the fluids are calculated into the percentage and are not documented separately. The DON indicated the only time the nursing staff document fluids consumed is when a resident has an order for a supplement. The DON indicated she did not have any documentation which indicated the amount of fluids resident (B) was consuming daily.</p> <p>On 11/13/14 at 11:55 a.m. review of the facility policy "Clinical</p>				

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	<p>Practice Standard" provided by the DON which was updated on 9/14 indicated the following:</p> <p>"Meal intake is to be documented for each patient. Fluids consumed as a portion of the routine meal are calculated per the point system and included in percentage of meal consumed."</p> <p>"Fluids are not documented separately in the AccuNurse/Vocollect system."</p> <p>This Federal Tag is related to complaint IN00158649</p> <p>3.1-46(b)</p>			