STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
R000000	This visit was for a State Licensure survey. Survey dates: November 25, 26, 2013 Facility Number: 003273 Provider Number: 003273 AIM number: N/A Survey Team: Carol Miller, RN, TC Diane Nilson, RN Rick Blain, RN Census bed type: Residential: 65 Total: 65 Census payor type: Other: 65 Total: 65 Sample: 7 These State Residential Findings are in Accordance with 410 IAC 16.2.. Quality review completed on	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	November 27, 2013 by Randy Fry RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
R000121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	Based on record review and interview, the facility failed to screen 5 new employees for tuberculosis in a sample on 10 new employees reviewed for employment tuberculosis testing (Staff #2, #3, # 4, #5, and #6). Findings include: 1. The record for Staff #4 was reviewed on 11/26/2013 at 8:30 A.M. The record did not indicate initial screening for tuberculosis using the Mantoux method (a screening tool for tuberculosis) had been completed within one month prior to starting employment. 2. The record for Staff #6 was reviewed on 11/26/2013 at 8:35 A.M. The record did not indicate initial screening for tuberculosis using the Mantoux method had been completed within one month prior to starting employment. 3. The record for Staff #2 was reviewed on 11/26/2013 at 8:40 A.M. The record indicated a start date of 8/7/2013. The record indicated an initial Mantoux was administered on 8/2/2013 and was interpreted on 8/5/2013. There was no documentation in the employee's record to indicate a second step	R000121	1. Corrective Actions to be accomplished for residents/employees found to be affected.Employees identified in the survey (#s 2,3,4,5,6) will be given a correct 2-step Mantoux with results documented in the employees' personnel records. 2. How facility will identify other residents (employees) potentially affected and what corrective actions will be taken.An audit will be made of the employee records. Deficiencies identified will be corrected as described in #1. above. 3. Systemic changes the facility will put into practice to ensure the deficient practice does not recur.The Business Office Director will monitor the timing and completion of TB testing for new employees using the New Employee Record Checklist and report in daily standup meeting to the Administrator and Resident Care Director regarding needed TB testing. New Employee Checklists will be kept in a separate file until complete, at which time they will be initialed by the Administrator and placed in the employee's record. In addition, each department head will retrained on TB testing requirements for employees, and directed to follow up on the TB testing status of new employees in their respective departments. 4. How the corrective actions will be monitored to ensure the deficient practice does not recur.The status of New	01/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	Mantoux (a follow up Mantoux completed within one to three weeks following the initial Mantoux) had been completed. 4. The record for Staff #3 was reviewed on 11/26/2013 at 8:45 A.M. The record indicated a start date of 9/18/2013. The record indicated an initial Mantoux was administered on 9/17/2013 and was interpreted on 9/19/2013. There was no indication in the employee's record to indicate a second step Mantoux had been completed. 5. The record for Staff #5 was reviewed on 11/26/2013 at 8:50 A.M. The record indicated a start date of 7/29/2013. The record indicated the initial Mantoux was administered on 7/26/2013 and was interpreted on 7/29/2013. The record indicated the second step Mantoux (a follow up Mantoux to be completed within one to three weeks following the initial Mantoux) was not administered until 10/1/2013. The facility Resident Care Director (RCD) was interviewed on 11/26/13 at 10:30 A.M. During the interview, the RCD indicated there was no documentation indicating the employee screening for tuberculosis		Employee Record Checklists will be reported in daily standup meeting to the Administrator and Resident Care Director. Each department head will report to the Administrator monthly on the TB test status of new hires in their respective departments. The Business Office Director will report on TB testing at monthly QA meetings to promote ongoing compliance. 5. By what date the systemic changes will be completed.Actions described above will be completed and systems implemented by January 15th, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	had been completed as required. The RCD further indicated the facility did have the PPD (purified protein derivative solution used in the Mantoux skin test) available to complete the employee Mantoux's during the time period in question and so that was not a factor in why the tuberculosis screening had not been completed. A facility policy entitled "Health Requirements", dated 11/01/2013, indicated "Emeritus screens all employees for tuberculosis before they begin working in any Emeritus community...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
R000178	410 IAC 16.2-5-1.6(b) Physical Plant Standards - Deficiency (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all areas. Based on observation, record review, and interview, the facility failed to ensure comfortable room temperatures were maintained in 1 of 3 dining areas. Findings include: During the medication pass on the Memory Care Unit, at 8:30 a.m., on 11/26/13, 8 residents were observed sitting in the small dining room waiting for breakfast to be served. The residents were all noted to be wearing either sweatshirts, sweaters, or jacket-type outerwear. 5 of the 8 residents in the room indicated they were cold. The Maintenance Director was called to the small dining room. The room temperature was taken and registered 69 degrees. The Maintenance Director indicated there was not an individual thermostat in the dining room, but the heat from the hallway heated the dining room. He indicated the doors to the dining room needed to be left open so the room would be heated. The Maintenance Director was observed to walk down the hallway, away from the dining room, and open a thermostat box, which was located across from the larger dining room on the Memory Care Unit. The thermostat was noted to read "75" degrees, and the Maintenance Director set the thermostat to 77	R000178	1. Corrective Actions to be accomplished for residents/employees found to be affected.(A) Until the implementation of 1.B below, the facility Maintenance Director or designee will check the temperature of the small dining room each morning and adjust the main unit thermostat as indicated. The facility Maintenance Director will recheck the temperature of the small dining periodically throughout the day to monitor for maintained temperature and will continue to adjust thermostat as indicated.(B) The facility Maintenance Director will provide necessary equipment and training to the memory care staff to measure the temperature of the small dining room. Memory care staff will check the temperature of the small dining room, adjust the main thermostat as needed, and re-check the temperature to verify that the temperature has reached at least 71 degrees F, or higher if residents are not comfortable, prior to meals and activities. 2.	12/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	degrees Fahrenheit (F). The room temperature in the small dining room was checked again at 8:45 a.m., on 11/26/13 and registered 73 degrees F. The Resident Care Director was interviewed, at 10:00 a.m., on 11/26/13, and indicated she had been working with the night shift to leave the doors to the dining room open since heat came into the room from the halls. She indicated she couldn't remember how long she had been working with the night shift regarding this issue. Review of the Indoor Air Temperatures policy, dated 11/5/12, and revised on 11/26/13, provided by the Administrator, at 11:05 a.m., on 11/26/13, and reviewed at this time, indicated, " (Facility name) communities shall maintain safe indoor air temperatures. "		How facility will identify other residents potentially affected and what corrective actions will be taken.Residents in the memory care unit are potentially affected. 3. Systemic changes the facility will put into practice to ensure the deficient practice does not recur.The facility will install a separate, UL-listed baseboard heating unit in the small dining room. As of the time of this installation, this unit will be adjusted to maintain a temperature of at least 71 degrees F, or higher if residents are not comfortable. 4. How the corrective actions will be monitored to ensure the deficient practice does not recur.The Memory Care Director or designee, will report in daily standup meeting to the Administrator the temperature status of the small dining room for the prior day and for the current day up to the time of daily standup meeting.5. By what date the systemic changes will be completed.Actions described under steps #1.A and #4 above will be completed/implemented by 12/13/13. Actions described under #1.B above will be completed/implemented by 12/18/13. Actions described under step #3 above will be completed by 1/17/13. Actions described under step #4 above will be implemented by 12/16/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
R000299	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to ensure a pharmacy recommendation was reported to the physician. This affected 1 of 7 residents reviewed for Pharmacy Drug Regimen Review (Resident #71). Findings include: The closed record for Resident #71 was reviewed, at 10:00 a.m., on 11/26/13. Physician orders, for November 2013, indicated Aspirin EC (enteric coated) 325 milligrams (mg.), give 1 tablet orally once a day. Review of a Pharmacy Consultation Report, dated 8/29/13, indicated the resident was receiving Aspirin 325 milligrams every day. The recommendation from the Pharmacist indicated, "Please consider requesting a decrease in aspirin dose to 81 mg. daily. " The physician's response section on the consultation report was not marked or signed by the physician. The Resident Care Director was interviewed, at 11:00 a.m., on 11/26/13, and indicated the Pharmacy Consultation Recommendations were supposed to be faxed to the physician, however she could find no documentation the recommendation for Resident #71 had been faxed for response. She further indicated there was no written policy for this.	R000299	1. Corrective Actions to be accomplished for residents/employees found to be affected.Resident #71 was discharged from the facility by the time of the survey. 2. How facility will identify other residents potentially affected and what corrective actions will be taken.The Administrator will review a copy of the most recent pharmacy report/recommendations and review the status of physician notification for each recommendation with the resident care director, to insure that notifications have been made and documentation completed. 3. Systemic changes the facility will put into practice to insure the deficient practice does not recur.The administrator will receive a copy of the pharmacy recommendations in a timely fashion. The current status of recommendations and notifications will be reviewed and reported in daily standup meeting by the resident care director to the administrator. 4. How the corrective actions will be monitored to ensure the deficient practice does not recur.The administrator will meet weekly with the resident care director to	12/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
			review status of current pharmacy recommendations and take action as indicated.5. By what date the systemic changes will be completed.12/17/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
R000408	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to obtain a diagnostic chest x-ray to screen for tuberculosis within six months prior to admission to the facility for 1 of 7 residents reviewed for admission chest x-rays (Resident #45). The record for Resident #45 was reviewed on 11/25/2013 at 1:00 P.M. The record for Resident #45 indicated a "community move in date" of 2/15/2013. The record indicated Resident #45 last had a chest x-ray completed on 7/15/2012 at another facility. The facility Resident Care Director (RCD) was interviewed on 11/26/2013 at 9:00 A.M. During the interview, the RCD indicated a screening chest x-ray had not been completed for Resident #45 within six months of admission to the facility. A facility policy, entitled "Tuberculosis Screening and Testing for Residents", with a revision date of 4/29/2013, indicated "Each state has different	R000408	1. Corrective Actions to be accomplished for residents/employees found to be affected.Resident #45 was given a first step Mantoux on 11/25/13, and will be given the second step on or before 12/13/13. 2. How facility will identify other residents potentially affected and what corrective actions will be taken.An audit of current resident records will be completed by the resident care director or designee to identify any other residents who lack documentation of a chest x-ray within six months prior to admission. For any residents determined to lack this documentation, the facility will administer a 2-step Mantoux according to test protocol. 3. Systemic changes the facility will put into practice to insure the deficient practice does not recur.The administrator will implement the use of a new resident move-in binder to include a check item for the obtaining of a record of a chest x-ray within six months prior to admission, or appropriate TB testing. Where no documentation can be obtained, the facility will secure an order for a new chest x-ray. 4. How the corrective actions will be monitored to ensure the deficient practice does not recur.The	01/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	requirements for resident tuberculosis screening/testing. These requirements are dictated by state regulations."		administrator will review the new resident move-in binder weekly with the resident care director to monitor that CXR or TB testing is completed and documentation on file prior to resident admission. 5. By what date the systemic changes will be completed.Actions described under #2 above will be completed by 1/21/13. Actions described under #3 and #4 will be implemented by 12/17/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to administer a Mantoux (a screening tool for tuberculosis) within three months of admission to the facility, or at the time of admission to the facility, for 1 resident (Resident #45) in a sample of 7 residents reviewed for tuberculosis screening. Findings include: The record for Resident #45 was reviewed on 11/25/2013 at 1:00 P.M.	R000410	1. Corrective Actions to be accomplished for residents/employees found to be affected.Resident #45 was given a first step Mantoux on 11/25/13, and will be given the second step on or before 12/13/13. 2. How facility will identify other residents potentially affected and what corrective actions will be taken.An audit of current resident records will be completed to identify other residents who lack documentation of a 2-step Mantoux test within 3 months prior to admission or upon admission. For any residents identified to lack this	01/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(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
	The record for Resident #45 indicated a "community move in date" of 2/15/2013. The record for Resident #45 did not indicate an admission Mantoux had been completed within three months prior to admission to the facility or at the time of admission to the facility. The facility Resident Care Director (RCD) was interviewed on 11/26/2013 at 9:00 A.M. During the interview, the RCD indicated no Mantoux had been administered to Resident #45 within three months prior to admission to the facility or at the time of admission to the facility. A facility policy, entitled "Tuberculosis Screening and Testing for Residents", with a revision date of 4/29/2013, indicated "Each state has different requirements for resident tuberculosis screening/testing. These requirements are dictated by state regulations."		documentation, the facility will administer a 2-step Mantoux according to test protocol. 3. Systemic changes the facility will put into practice to ensure the deficient practice does not recur.The administrator will implement the use of a new resident move-in binder to include a check item for the obtaining of a record of a tuberculin skin test within 3 months prior to admission or upon admission. The Resident Care Director will review documentation of new residents to monitor that appropriate TB testing is completed prior to move in. 4. How the corrective actions will be monitored to ensure the deficient practice does not recur.The administrator will review the new resident move-in binder weekly with the resident care director to monitor documentation of completion of a 2-step Mantoux test within 3 months prior to admission or upon admission, for new residents. 5. By what date the systemic changes will be completed.Actions described under #2 above will be completed by 1/21/13. Actions described under #3 and #4 will be implemented by 12/17/13.	