STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/22/2011
NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE ROAD FORT WAYNE, IN46809	

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F0000	This visit was for the Investigation of Complaint IN00096682. Complaint IN00096682 -Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F323, F332, and F514. Survey dates: September 21, and 22, 2011. Facility number: 000498 Provider number: 155654 AIM number: 100266110 Survey team: Christine Fodrea, RN, TC Diane Nilson, RN Census bed type: SNF/NF: 62 Total: 62 Census payor type: Medicare: 8 Medicaid: 45 Other: 9 Total: 62 Sample: 6 Supplemental Sample: 4	F0000		

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.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 28, 2011 by Bev Faulkner, R.N.			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure medications were given as prescribed by the physician for 1 of 6 residents reviewed for medications given according to the physician's order in a sample of 6 (Resident #M). Findings include: 1. Resident #M's record was reviewed 9/21/2011 at 2:30 p.m. Resident #M's diagnoses included but were not limited to dementia, depression and aphasia (inability to speak). A physician's order written 8/4/2011 indicated to place a Scopolamine patch daily for the next 30 days to stop on 9/3/2011. The Medication Administration Record, dated 9/2011, indicated the Scopolamine patch had been given with out physician's	F0282	F 282 I. The facility is unable to correct the previous past alleged deficient practice for resident #M. II. All residents have the potential to be affected by the alleged deficient practice. III. Nurses/QMA'S to be in-serviced regarding Medication Administration/Medication Five Rights emphasizing blocking off the timed orders on the medication administration record. IV. The DON/ADON/Designee to audit the Medication Administration Records for all residents 2x' s/week for 4 weeks, 1x/week for 4 weeks, every other week for 1 month and then monthly ongoing. Physician orders to be reviewed during Departmental Daily Meetings Monday – Friday by the DON/Designee . Medication Administration Audits to be reviewed by the Administrator/DON/Designee monthly ongoing for any	10/17/2011

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	order on 9/4, 5, 6, 7, and 8 in the morning at 8 a.m. In an interview with the Assistant Director of Nursing on 9/22/2011 at 10:00 a.m., she indicated the medication should not have been given. This Federal citation relates to Complaint number IN00096682 3.1-35(g)(2)		educational needs and/or systematic changes. V. To be completed by 10-17-2011.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a safe environment and supervision as medications were observed to be left at the bedside or at the dining table for 2 of 10 residents observed for medication administration. (Residents #Q and Resident #R) Findings include:	F0323	F 323 I. The facility is unable to correct the previous alleged deficient practice for resident's # Q & R. II. All residents have the potential to be affected by the alleged deficient practice. III. Nurses/QMA'S to be in-serviced regarding Medication Administration, Medication Five Rights and emphasizing the reading of medication labeling to ensure the	10/17/2011

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	1. During an extended medication pass observation on 9/22/2011 at 8:15 a.m., QMA #1 prepared medication for Resident #Q. She crushed the crushable medications, placed them in applesauce, and prepared the other medications in a medicine cup and a 4 ounce drinking glass. After preparing the medications, QMA#1 set the crushed medications in applesauce, and medications in the medicine cup on the breakfast table in front of Resident #Q. She then mixed the medication in the 4 ounce drinking glass with water from the table and indicated the medication needed to be taken with 4 ounces of water. She then left the table stating Resident #Q preferred to wait until breakfast was over to take her medications. Resident #Q's record was reviewed 8/22/2011 at 8:45 a.m. Resident #Q's diagnoses included but were not limited to diabetes, anxiety and dementia. When asked why she didn't wait until Resident #Q was finished with her meal to assure the medicines were taken, QMA#1 indicated staff never knew when Resident #Q would finish and want her medicine.		orders/recommendations are followed appropriately. IV. DON/ADON/Designee to observe medication passes 2x's/week for 4 weeks, 1x/week for 4 weeks, 2x/month for 4 weeks and monthly thereafter ongoing. Medication Observations to be reviewed by the Administrator/DON/Designee monthly ongoing for any possible educational needs and/or systematic changes. V. To be completed by 10-17-2011.	

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	2. During an extended medication pass observation on 9/22/2011 at 8:30 a.m., QMA #1 prepared Resident #R's medications in a medicine cup and took the medicines in to Resident #R's room setting them on the overbed table, making sure the water was in reach. QMA #1 then left the room. In an interview on 9/22/2011 at 8:35 a.m., Resident #R indicated the staff always leave her medicines on her breakfast tray to take. A current undated policy provided by the nurse Consultant on 9/22/2011 at 3:25 p.m., titled Medication Five Rights indicated "...#7. Do not leave medication at the bedside...." The October 2003 Qualified Medication Aide Basic Curriculum indicated in Lesson 2 to follow the policies of your facility. This Federal citation relates to Complaint number IN 00096682. 3.1-45(a)(1)			

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F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 10 residents observed receiving medications. 3 errors in medication were observed during 45 opportunities for error. This resulted in a medication error rate of 6%. (Resident #N, Resident #T and Resident #Q) Findings include: 1. During the medication pass at 3:55 p.m., on 9/21/11, LPN #3 removed Coreg 25 milligrams, 1 tablet, from the bubblepack medication card, and Ferrous Sulfate, 325 milligrams, 1 tablet, from the bubblepack medication card for Resident #N, and placed the medications in the medication cup for the resident. LPN #3 indicated she was ready to give the medication to Resident N. When the medication card for the Coreg was observed, the label indicated Coreg 25 milligrams(mg), give 2 tablets (50 mg), orally 2 times a day. When this was brought to the LPN's attention, she reviewed the MAR again, and then took another Coreg 25 milligrams from the	F0332	F 332 I. DON to instruct newly hired Nurse in question regarding resident #N's Coreg order. Since no medication error occurred this will be the only intervention. The facility is unable to correct the alleged deficient practice for resident #T and Q. II. All residents have the potential to be affected by the alleged deficient practice III. Nurses/QMA'S to be in-serviced regarding Medication Administration, Medication Five Rights and emphasizing the reading of medication labeling to ensure orders/recommendations are followed appropriately. IV. DON/ADON/Designee to observe medication passes 2x's/week for 4 weeks, then 1x/week for 4 weeks, 2x/month for 4 weeks and monthly ongoing. Medication Observations to be reviewed by the Administrator/DON/Designee monthly ongoing for any possible educational needs and/or systematic changes. V. To be completed by 10-17-2011.	10/17/2011

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	bubblepack and placed it in the medication cup. Review of the current physician orders, for Resident #N, on the morning of 9/22/11, indicated Coreg 25 milligrams, give 2 tablets (50 mg) orally 2 times a day. 2. During the medication pass at 4:55 p.m., on 9/21/11, QMA #4 was observed to give Resident #T Meloxicam 7.5 milligrams, along with 2 other medications. The resident was observed to take the medication with water. The bubblepack for the Meloxicam was labeled with a warning, "May cause dizziness take with food/meal limit alcohol use while taking. " QMA #4 was questioned and indicated the resident would be eating dinner at 6:00 p.m. Review of the physician orders and MAR for September, 2011, on the morning of 9/22/11, indicated Meloxicam 7.5 milligrams, give 1 tablet orally, 2 times a day, but did not have a warning regarding giving the medication with food or a meal. 3. During an extended medication pass observation on 9/22/2011 at 8:15 a.m., QMA #1 prepared medication for Resident #Q. She crushed the crushable			

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	medications, placed them in applesauce, and prepared the other medications in a medicine cup and Miralax (a laxative) in a 4 ounce white plastic cup. After preparing the medications, QMA#1 set the crushed medications in applesauce, and medications in the medicine cup on the breakfast table in front of Resident #Q. She then mixed the Miralax in the 4 ounce white plastic cup with water from the table and indicated Miralax needed to be taken with 4 ounces of water. Resident #Q's record was reviewed 8/22/2011 at 8:45 a.m. Resident #Q's diagnoses included but were not limited to diabetes, anxiety and dementia. A physician's order, dated 9/2011, indicated Resident #Q was to receive Miralax powder (a laxative) 1 capful dissolved in 8 ounces of liquid one time per day. In an interview with Dietary Aide #5 on 9/2/2011 at 9:10 a.m., she indicated the green drinking glasses were 8 ounces and the white plastic cups used for medication pass was a 4 ounce cup. The Medication Administration Record, dated 9/2011, indicated the Miralax was to be given in 8 ounces of liquid.			

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	A current undated policy provided by the Nurse Consultant on 9/22/ 2011 at 3:25 p.m., titled "Medication Five Rights" indicated to check the drug label and to verify the medication with the Medication Administration Record. This Federal citation relates to Complaint number IN00096682 3.1-25(b)(9) 3.1-48(c)(1)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review and interview, the facility failed to ensure accurately documented medication orders for 1 of 4 residents reviewed for medication orders (Resident #S) and	F0514	F 514 I. The facility is unable to correct the previous alleged deficient practice for resident #S but the order for resident was corrected to indicate "May administer medications by	10/17/2011

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	accurate documentation on the Medication Administration Record for 3 of 6 residents reviewed for medication administration documentation. (Resident #P, Resident #O, Resident #R) Findings include: 1. During the medication pass with QMA #2 at 12 noon, on 9/21/11, the QMA was observed to give Resident #S, two medications through the Gastrostomy tube (GT). The medications were Clonidine 0.2 milligrams, and Hydralazine, 10 milligrams. Review of the physician orders for September, 2011, on 9/22/11, at 10:00 a.m., indicated the following: Clonidine HCL 0.2 mg tablet, give 1 tablet orally 3 times a day, and Hydralazine 10 mg. tablet, give 1 tablet, orally, 4 times a day. The MAR for September, 2011, also indicated to give the 2 medications orally. The DNS was interviewed, at 2:45 p.m. on 9/22/11, and indicated the resident received all of her medications by GT now even though the physician orders indicated by mouth. The DNS indicated the resident had been choking when given the medication by mouth, and refused to take the medications by mouth. She indicated the previous orders and MAR in		mouth or g-tube. The facility clarified the order for Mag Delay 128milligrams on the medication administration record to read (give 2- 64mg tablets) twice a day on resident #O . The facility is unable to correct the alleged deficient practice for resident # R. The Coumadin order for resident #R was corrected to read give 6.5milligrams daily. II. All residents have the potential to be affected by the alleged deficient practice. III. The DON/ADON/Designee to audit the Medication Administration Records for all residents 2x's/week for 4 weeks, 1x/week for 4 weeks, 2x's/month for 4 weeks and then monthly ongoing. Nursing staff to be in-serviced regarding Medication Administration/Medication Five Rights emphasizing documentation. IV. Medication Administration Record audits to be reviewed by the Administrator/DON/Designee monthly ongoing for any educational needs and/or systematic changes. V. To be completed by 10-17-2011.	

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	July, 2011, had indicated the resident was receiving the medications by GT, but when the resident came back from the hospital in August, 2011, the nurse did not re-write the physician orders to indicate GT medications, so the re-writes and MARS indicated the medications were to be given by mouth. 2. Review of the record for Resident #P, at 3:10 p.m. on 9/21/11, physician orders for September, 2011, indicated the resident was to receive Depakote 125 milligram (mg) sprinkles, 4 capsules (500mg) orally daily at bedtime. Review of the Medication Administration Record (MAR) for September, 2011, indicated there were blanks (no initials to indicate the medication had been given), on September 2, 3, 4, 9, and 14, 2011. A physician order, dated 8/30/11, indicated the resident was to receive Abilify 5 milligrams, by mouth, at bedtime. The MAR, for September, 2011, indicated blanks on September 2, 3, 4, 5, 6, 9, and 14, 2011. In an interview on 9/22/2011 at 2:30 p.m., the Director of Nursing indicated she was aware there was need to improve documentation and the facility would be working on it.			

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	3. The record for Resident #O, was reviewed at 10:30 a.m., on 9/22/11. A physician's order, dated 9/2/11, indicated to increase the Slow-Mag 64 milligrams, 2 tabs, to twice a day by mouth. Review of the MAR for September, 2011, indicated, "Mag Delay 128 mg (milligrams) (2 tabs) BID (twice a day). Initials on the MAR for September, 2011, indicated the medication had been given starting 9/2/11, twice a day, with circled initials on 9/14, 16, 17, 18, 19, 20, and 21, which indicated the medication was not given. The bottle of Mag Delay was observed in the medication cart with the Director of Nurses(DNS) at 1:40 p.m., on 9/22/11. The instructions on the bottle indicated, "Mag Delay 64 mg tab, give 2 tabs (128 mg) orally, once a day." The DNS indicated the physician had increased the medication to 64 milligrams, twice a day, on 9/2/11, but whoever transcribed the order to the MAR wrote 128 milligrams, twice a day. She indicated this was written incorrectly, but the resident had been receiving 64 milligrams, twice a day. 4. Resident #R's record was reviewed 9/22/2011 at 9:10 a.m. Resident #R's diagnoses included but were not limited to			

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	dementia, high blood pressure, and atrial fibrillation (a heart beat malfunction). A physician's order, dated 9/19/2011, indicated Coumadin (a blood thinner) 6.5 mg was to be administered daily. The Medication Administration Record, dated 9/2011, did not include any initials indicating Coumadin had been given. In an interview with LPN #6 on 9/22/2011 at 2:45 p.m., she indicated the medication had been given, but not charted. She did not indicate why the medication had not been charted. A current policy dated 9/2205 (sic) titled Administration Documentation Procedure and guidelines indicated the assigned nurse is responsible to accurately record data in the clinical record on the appropriate form. This Federal citation relates to Complaint number IN00096682. 3.1-50(a)(2)			