STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF FORT WAYNE	**1649 SPY RUN AVENUE FORT WAYNE, IN 46805**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a residents medications were secured and recomciled for 1 of 3 residents receiving a controlled substance. (Resident B) Findings include: A review of Resident B's record on 8/12/2020 at 10:35 a.m., indicated they had a BIMS (Brief Interview of Mental Status) score of 12, meaning moderate cognitive impairment. The score was obtained from the MDS (Minimum Data Set) Quarterly Assessment, dated 6/29/2020. Resident B was also identified by the facility as being alert and oriented, to person, place, and time. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The order also indicated the medication may be held if the resident was sedated or sleeping. During a confidential interview on 8/12/2020 at 2:52 p.m., the interviewee indicated on Saturday morning, June 27, 2020, they counted the narcotics on the [MEDICATION NAME] Back Hall medication cart with day shift LPN 1, and the count was correct. The complainant indicated they went home because their shift was over. LPN 1 had indicated that she usually does not work that hall and was going to trade with LPN 6. The LPN's traded halls and medication carts, but never counted the narcotic medications when the personnel change was completed. They received a phone call from the ADON (Assistant Director of Nursing) that evening. she indicated they were missing 11 [MEDICATION NAME] belonging to Resident B. The ADON indicated to the interviewee, LPN 6 and the oncoming nurse, RN (Registered Nurse) 8 counted the narcotics. There were missing [MEDICATION NAME]. Four nurses had to write statements to give to the ADON. The 2 day shift nurses were drug tested . LPN 6 later bragged her test came back positive and she still got to keep her job. They no longer work there due to this problem, because it has happened before with LPN 6 and the administration has not done anything about it. During an interview on 8/12/2020 at 3:30 p.m., the ADON indicated she was called in on a Saturday, June 27, for a concern with narcotic discrepancy, involving Resident B's [MEDICATION NAME], 11 were missing and not accounted for. She indicated the narcotic sheet had a count of 12. The medications in the narcotic medication card were 1. The ADON admitted to drug testing LPN 1 and LPN 6 on 6/28/2020. The ADON indicated LPN 6's test came back positive for opiates. The ADON indicated LPN 6 informed her that she was on prescribed [MEDICATION NAME] (a narcotic used for pain). The ADON indicated she did not know that LPN 6 was on a prescribed narcotic before the discrepancy. The ADON indicated that Resident B had not missed any of his doses of [MEDICATION NAME]. During an interview on 8/13/2020 at 11:15 a.m., the facility Pharmacist indicated she knew nothing about the discrepancy due to working remotely because of Covid. She indicated she did learn of it when the ED (Executive Director) indicated to her they wanted to put cabinets in the medication rooms for the narcotics, so they could have cameras in the rooms. During an interview on 8/13/2020 at 11:30 a.m., the ED indicated that she did not know LPN 6 was on a prescribed narcotic before the medication discrepancy. She indicated that LPN 6 had showed her a picture of the prescription but the date was not visible, and a hard copy had not been provided to the facility. During an interview on 8/13/2020 at 4 p.m., LPN 1 indicated that her and LPN 6 had not counted the narcotics prior to trading halls and carts, she knows that was wrong and she was disciplined for it. She further indicated when she did the count with the off going QMA that morning of 6/27 the count was correct. She indicated she did not know what happened to the pills. The Pharmacist and the Pharmacist's General Manager, on 8/13/2020 at 12:55 p.m., indicated the following: The prescription of [MEDICATION NAME] for Resident B was filled on 6/22/2020. 42 tablets which would have been a 7 day supply; an every 4 hour routine scheduled medication. LPN 3 had called the pharmacy on 6/26 to obtain a refill, to make sure they did not run out over the weekend. At that time, the pharmacy technician noted that it was too soon to refill as the prescription could only be refilled on 6/29. LPN 3 had counted 20 tablets at that time (10 a.m. on 6/26). On 6/27/2020 30 tablets of [MEDICATION NAME] were filled and a note in the pharmacy dispensing system was made to bill the facility for 30 tablets per the ADON. A review of the Controlled Substance Record, narcotic count sheets, indicated on 6/22/2020 they started the count on the first line at 41 tabs, beginning quantity was 42 tabs. The last documented dose was signed out on 6/27/2020 at 4 p.m.by LPN 6, the count was 12 tabs, with 2 blank lines left to finish the sheet. The second narcotic sheet reviewed indicated the facility had 42 tabs. The first line was dated 6/27/2020, signed at 8 p.m., by RN 8 and ADON for 1 tab administered. The quantity remaining was 0. A third narcotic sheet was reviewed. The first date was 6/28/2020, 1 tab was signed out at 4 a.m. by RN 8 and 29 pills remained. A review of untitled forms used at shift change indicated LPN 6 never confirmed the narcotic card count on 6/27/2020 as the oncoming shift. A review of LPN 6's employee file on 8/13/2020 at 4:55 p.m., indicated there was no documented prescription from a medical professional, nor any documentation indicating the need for such narcotic prescription. During an interview on 8/14/2020 at 2:20 p.m., the ED indicated they had no confirmed evidence that LPN 6 had a prescription for a controlled substance. The ED further indicated LPN 6 was on FMLA(Family and Medical Leave Act) currently. This Federal citation is related to IN 589. 3.1-28(a)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Care Plans were developed, implemented and updated for 2 of 4 residents reviewed. (Resident C, Resident) Findings include: 1. On 8/14/2020 at 12 p.m., Resident C was observed in their room, and laying in their bed. A review of Resident C's record on 8/11/2020 at 3:42 p.m., indicated the resident had a BIMS (Brief Interview of Mental Status) score of 14, meaning cognitively intact. The score was obtained from the MDS (Minimum Data Set) Annual Medicare 5 day Assessment, dated 7/9/2020. [DIAGNOSES REDACTED]. The MDS Annual Medicare 5 day Assessment, dated 7/9/2020 indicated the following Functional Status for ADL's (Activities of Daily Living): Bed mobility was limited assistance with 1 physical assist from staff. Transfers were extensive assistance with 1 physical assist from staff. Walking required a physical assist from staff. Dressing, toileting, and personal hygiene were extensive assistance with 1 physical assist from staff. A review of Resident C's Care Plans indicated no were developed or implemented Care Plan for ADL's. During an interview on 8/14/2020 at 1:25 p.m., the ADON (Assistant Director of Nursing) indicated they had been educating Resident C to request assistance from staff when he wanted to ambulate, she further indicated Resident C should have had a Care Plan for ADL's, and he did not. 2. A list of falls provided by the DON (Director of Nursing) on 8/12/2020 at 1 p.m., indicated Resident C had falls on the following dates: 3/24/2020, 4/27/2020, 6/19/2020, 8/7/2020, and 8/11/2020. A review of the Fall Care Plan indicated there were no updated interventions since 4/28/2020. During an interview on 8/14/2020 at 1:25 p.m., the ADON (Assistant Director of Nursing) indicated they had been educating Resident C to request assistance from staff when he wanted to ambulate, and the care plan should have had more current interventions in place. A current facility policy, Fall Management, dated 4/15/2019, provided by the facility, laying on the conference table on 8/14/2020 at 10:35 a.m., indicated the following: .The interdisciplinary team will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change and quarterly MDS, upon a fall event and as needed thereafter . 3. On 8/11/2020 at 12:20 p.m., Resident M was observed in her room, lying in bed,

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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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) slightly turned to her right side, and sheets were pulled up over her chest. On 8/13/2020 at 5 p.m., Resident M was observed in her room, lying in bed, sheets were pulled up over her chest. On 8/14/2020 at 11:45 a.m., Resident M was observed in her room, lying in bed, slightly on her right side, and sheets were pulled up over her chest. A review of Resident M's record on 8/11/2020 at 2:43 p.m., indicated a BIMS score of 15, meaning cognitively intact. The score was obtained from the MDS Quarterly Assessment, dated 7/11/2020. [DIAGNOSES REDACTED]. During an interview on 8/11/2020 at 12:20 p.m., Resident M indicated she prefered to just have the sheets cover her, as opposed to wearing clothing or a facility gown. A review of the ADL Care Plan did not indicate Resident M's preference for just a sheet preference under the dressing section. During an interview on 8/14/2020 at 1:25 p.m., the ADON indicated the preference to wear sheets was not care planned and it should have been. A current facility, Resident Assessment Instrument & Care Plan, dated 4/29/2019, provided by the facility, on the conference table, on 8/14/2020 at 10:35 a.m., indicated there had been no Care Plan updates. A current facility policy, Resident Assessment Instrument & Care Plan, dated 4/29/2019 and provided by the facility, laying on the conference table on 8/14/2020 at 10:35 a.m., indicated the following: .The Care Plan includes measure objectives, timeframes to meet the patient's, cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs . This Federal Citation is related to Complaints IN 570, and IN 402. 3.1-35(c)(1)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that pain medication was administered at the ordered time for 1 of 3 residents reviewed. (Resident B) Findings include: A review of Resident B's record on 8/12/2020 at 10:35 a.m., indicated a BIMS (Brief Interview of Mental Status) score of 12, meaning moderate cognitive impairment. The score was obtained from the MDS (Minimum Data Set) Quarterly Assessment, dated 6/29/2020. Resident B was also identified by the facility as being alert and oriented, to person, place, and time. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A review of the EMAR (Electronic Medication Administration Record) indicated Resident B received his [MEDICATION NAME] pain medication early without the allotted 4 hour's between administrations. The following dates and times were documented: 3/5/2020 at 7:47 a.m., and 11:14 a.m., administered by LPN 6. 3/8/2020 at 11:06 a.m., and 1 p.m., administered by LPN 6. 3/9/2020 at 7:46 a.m., and 11:13 a.m., adminisitered by LPN 6. 3/12/2020 at 7:42 a.m., and 11:25 a.m., administered by LPN 6. 3/17/2020 at 7:44 a.m., and 11:26 a.m., administered by LPN 6. 3/19/2020 at 7:49 a.m., and 11:06 a.m., administered by LPN 6. 3/22/2020 at 8:57 a.m., and 12:39 p.m., administered by LPN 6. 3/26/2020 at 8:02 a.m., and 11:10 a.m., administered by LPN 6. 3/31/2020 at 8:02 a.m., and 11:39 a.m., administered by LPN 6. 4/4/2020 at 7:57 a.m., and 11:21 a.m., administered by LPN 6. 4/5/2020 at 12:09 p.m., and 3:24 p.m., administered by LPN 6. 4/10/2020 at 7:38 a.m., and 11:09 a.m., administered by LPN 6. 5/2/2020 at 8:02 a.m., and 11:39 a.m., and 3:04 p.m., administered by LPN 6. 5/3/2020 at 7:41 a.m., and 11:03 a.m., administered by LPN 6. 5/25/2020 at 8:06 a.m., and 11:29 a.m., administered by LPN 6. 6/5/2020 at 9:11 a.m., and 11:50 a.m., administered by LPN 6. During an interview on 8/13/2020 at 11:15 a.m., the facility Pharmacist indicated a prn (as needed) pain medications are to be given at the exact hour interval or later, but not before. She indicated if the order is to give every 4 hours as needed, there must be 4 hours between doses. If the medication is scheduled, she indicated the medication may be given an hour before or an hour after the scheduled time. During an interview on 8/14/2020 at 3:50 p.m., LPN 1 indicated a nurse would not give a prn narcotic for pain early. She indicated if they got one at 12 p.m., and it is for every 4 hours prn, they wouldn't get another pill until 4 p.m. A current facility policy, Medication Administration Times, dated 5/1/2010, indicated the following: .Facility should ensure that authorized personnel, as determined by applicable law, administer medications according to times of administration as determined by facility's pharmacy committee and/or physician/prescriber . The facility policy did not have documented information regarding prn pain medications. This Federal Citation is related to Complaint IN 589, IN 969, and IN 431. 3.1-35(g)(1)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to document, investigate, and prevent a fall for 1 of 3 residents reviewed. (Resident B) Findings include: On 8/14/2020 at 11:25 a.m., Resident B was observed in his room, lying in bed watching TV. On 8/14/2020 at 2:35 p.m., Resident B was in his room, standing by his closet. On 8/14/2020 at 3:55 p.m., Resident B was in the front lobby, with his walker, talking to the DON (Director of Nursing). A review of Resident B's record on 8/12/2020 at 10:35 a.m., indicated a BIMS (Brief Interview of Mental Status) score of 12, meaning moderate cognitive impairment. The score was obtained from the MDS (Minimum Data Set) Quarterly Assessment, dated 6/29/2020. Resident B was also identified by the facility as being alert and oriented, to person, place, and time. [DIAGNOSES REDACTED]. During an interview on 8/14/2020 at 11:25 a.m., Resident B indicated about a month ago he had fallen in his room, near his night stand. He told the CNA, around 8 p.m. that evening that there was a spill on the floor in the middle of the room, but nobody came to clean it up until about 3 hours later. The CNA had put a sheet on it to clean it up. He indicated, at around 11 p.m. that night, he got up to use the bathroom and on his way out of the bathroom, he slipped on the liquid, in the middle of the room, and fell on his right knee and left shoulder. He indicated he was able to belly crawl to his night stand where he could reach his call light. The nurse came and assisted him to bed, he could not remember the nurses name, but she helped him. Resident B could not remember the date of the fall, but indicated he had xrays done. During an interview, on 8/14/2020 at 11:50 a.m., LPN 1 and CNA 5 indicated they were unaware of Resident B's fall. During an interview, on 8/14/2020 at 12 p.m., the ADON (Assistant Director of Nursing) indicated she was unaware of Resident B's fall. After the ADON discussed with the NP (Nurse Practitioner) she indicated the resident had told the NP about falling around the July 4th Holiday. During an interview, on 8/14/2020 at 2:35 p.m., Resident B indicated he remembered the fall occurred on his Birthday, July 11, on the night shift. A review of a Progress Note dated 7/20/2020 at 12:30 p.m., indicated the NP documented the nursing request for complaints of right shoulder, knee pain, and left rib pain. Resident B had reported to the NP he had a fall over the holiday weekend. The NP indicated there were no documented falls and Resident B continued to ambulate independently. A review of a Progress Note dated 7/21/2020 at 4:02 a.m., indicated the xrays were completed. Results were negative for rib fractures, [MEDICAL CONDITION] changes to the left shoulder, and right knee was negative for any findings. The note indicated continue to monitor. A current facility policy, Fall Management, dated 4/15/2019, indicated the following: .Avoidable Accident means that an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident including the need for supervision and/or assistive devices .Evaluate/analyze the hazards and risks and eliminate them, if possible, or if not possible, identify and implement measures to reduce the hazards/risks as much as possible .A fall refers to unintentionally coming to rest on the ground, floor or other lower level .if he or she had not caught him/herself, is considered a fall .A fall without injury is still a fall . This Federal Citation is realted to IN 570. 3.1-45(a)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure medication was documented accurately for 1 of 3 residents reviewed. (Resident T) Findings include: A review of Resident T's record on 8/12/2020 at 3 p.m. [DIAGNOSES REDACTED]. Interveiw with facility staff indicated the resident was interviewable. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A review of the April 2020 EMAR (Electronic Medication Administration Record) indicated no documentation [MEDICATION NAME] 5-325 mg was administered on 4/6/2020 and 4/8/2020 to Resident T. A review of the Controlled Substance Record indicated on 4/6/2020 at 4:51 a.m., a [MEDICATION NAME] 5-325 mg was signed out for [MEDICAL TREATMENT] and on 4/8/2020 at 5:05 a.m., a [MEDICATION NAME] 5-325 mg was signed out for [MEDICAL TREATMENT]. A review of the August 2020 EMAR indicated no documentation [MEDICATION NAME] 7.5-325 mg was administered on 8/4/2020. A review of the Controlled Substance Record indicated on 8/4/2020 at 3 p.m., the [MEDICATION NAME] 7.5-325 mg was signed out for administration. During an interview on 8/14/2020 at 1:25 p.m., the ADON(Assistant Director of Nursing) indicated the nurses were to document medication administration on the EMAR, but the document had not been completed. The facility provided no documentation policy. This Federal Citation is realted to IN 589, IN 969, and IN 431. 3.1-50(a)(1)(2)

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)