| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **155654** | A. BUILDING _____ B. WING _____ | **10/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **ENGLEWOOD HEALTH & REHABILITATION CENTER** | **2237 ENGLE RD FORT WAYNE, IN 46809** |

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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, and record review, the facility failed to ensure residents were being assessed daily for signs and symptoms of Covid-19, and documented findings for 8 of 8 residents reviewed. (Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, and Resident 27) Findings include: 1. A review of Resident 20's record on 10/22/2020 at 1:20 p.m., indicated [DIAGNOSES REDACTED]. A review of the Physician order [REDACTED]. There was no assessment, or evaluation completed for the month of October. 2. A review of Resident 21's record on 10/22/2020 at 1:25 p.m., indicated [DIAGNOSES REDACTED]. A review of the Physician order [REDACTED]. There was no assessment, or evaluation completed for the month of October. 3. A review of Resident 22's record on 10/22/2020 at 1:30 p.m., indicated [DIAGNOSES REDACTED]. A review of the Physician order [REDACTED]. There was no assessment, or evaluation completed for the month of October. 4. A review of Resident 23's record on 10/22/2020 at 1:35 p.m., indicated [DIAGNOSES REDACTED]. A review of the TAR's (Treat Administration Records), indicated no daily Covid-19 assessments had been completed for 9 days, on the following dates 10/13 through 10/21/2020. 5. A review of Resident 24's record on 10/22/2020 at 1:40 p.m., indicated [DIAGNOSES REDACTED]. A review of the TAR's indicated no daily Covid-19 assessment had been completed on 10/9/2020. 6. A review of Resident 25's record on 10/22/2020 at 1:45 p.m., indicated [DIAGNOSES REDACTED]. A review of the TAR's indicated no daily Covid-19 assessment had been completed on 10/2, 10/7, and 10/14/2020. 7. A review of Resident 26's record on 10/22/2020 at 1:50 p.m., indicated [DIAGNOSES REDACTED]. A review of the TAR's indicated no daily Covid-19 assessment had been completed on 10/2, 10/7, and 10/14/2020. 8. A review of Resident 27's record on 10/22/2020 at 1:55 p.m., indicated [DIAGNOSES REDACTED]. A review of the TAR's indicated no daily Covid-19 assessment had been completed on 10/2, and 10/7/2020. During an interview on 10/22/2020 at 1:15 p.m., the DON (Director of Nursing) indicated all residents were to be assessed daily for Covid-19 signs and symptoms that included the following: temperature, a change in eating habits, nausea, vomiting, diarrhea, and confusion. The residents were also to have a completed respiratory evaluation daily. During an interview on 10/22/2020 at 2:20 p.m., the DON indicated all residents should have had a Physician order [REDACTED]. During an interview on 10/22/2020 at 3 p.m., RN (Registered Nurse) 1 indicated that all residents were to be screened every day for Covid-19, and have their temperature taken. She further indicated that each area to be assessed popped up on the TAR on the computer. A current facility policy, Covid-19- Admission/Readmission/Transfer Criteria, dated 4/10/2020, provided by the DON on 10/22/2020 at 2:17 p.m., indicated that residents would be screened for the following: .presence of respiratory illness (cough, sore throat, shortness of breath, difficulty breathing (without underlying disease such as [MEDICAL CONDITIONS]), fever or new onset of confusion, nausea/diarrhea . .Residents will be monitored for signs and symptoms of respiratory illness, fever, and changes in cognitive status every day . 3.1-18(a) |

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