STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 8 and 11, 2024. Facility number: 014512 Residential Census: 123 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 13, 2024	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Evergreen Village at Fort Wayne desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 04/03/2024. Evergreen Village at Fort Wayne is respectfully asking for a desk review on this Plan of Correction.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Grim	Regional Director of Clinical Services	03/26/2024

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	site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview, and record review, the facility failed to ensure staff certified in cardiopulmonary resuscitation (CPR) and first aid were present for 6 of 21 shifts reviewed. 123 residents resided in the facility. Findings include: During a record review conducted on 3/11/24 at 11:09 AM, staffing records from the period of 3/4/24 to 3/10/24 were reviewed. On 3/5/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 3/6/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 3/7/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 3/8/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 3/9/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00	R 0117	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. A full audit was completed on 3/12/24 of all nursing staff certifications to identify staff out of compliance with CPR certification. There will be at least one person per shift, daily, to be CPR and First Aid Certified. CPR certification class to be offered on site April 3rd and will continue to offer classes until standards are met or exceeded. **What measures will be put in place or what systemic**	04/03/2024

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	AM. On 3/10/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. During an interview on 3/11/24 at 12:10 P.M., the Administrator indicated she had provided all available CPR and first aid certification records. She also indicated a CPR and first aid certified staff member should be present in the facility at all times.She indicated she was unable to find a facility policy pertaining to first aid certification. A policy titled CPR Certification dated 6/2022 provided by the Administrator on 3/11/24 at 12:10 P.M., indicated it was the responsibility of the Director of Nursing to ensure at least one on-duty employee had a current CPR certification at all times.		**changes the facility will make to ensure the deficient practice does not recur?** Evergreen Village will offer free CPR/First Aid classes to all employees, to ensure at minimum, one CPR and First Aid certified staff member per shift. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place and** DON or designee will audit nursing schedules weekly for 3 months, monthly for 3 months to ensure compliance with CPR and first aid certified staff present for all shifts. DON or designee will forward audits to Executive Director and to the QAPI team monthly x 6 months. QAPI will review and make recommendations as needed. **By what date the systemic changes will be completed.** 4/3/2024	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.	R 0247	**What corrective action will be**	04/03/2024

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	Based on observation, interview, and record review the facility failed to ensure medication errors were documented and reported to the physician for one of five residents reviewed (Resident 10). Findings include: During an observation and interview on 3/8/24 at 10:15 AM Qualified Medicine Aide (QMA) 2 was observed preparing medications to administer to Resident 10. QMA 2 indicated Resident 10's potassium chloride (a medication used for heart disease) and escitalopram (a medication used to treat depression) were not in the medication cart and not available to administer to Resident 10 as ordered. QMA 2 notified Licensed Practical Nurse 3, who indicated he would contact the pharmacy to obtain the missing medications. Resident 10's record was reviewed on 3/11/24 at 9:32 AM. Diagnoses included major depressive disorder, hypertension, and atherosclerotic heart disease. Physician orders dated 2/17/23 indicated a potassium chloride 10 meq tablet should be given to Resident 10 once daily. A physician's orders dated 11/23/23 indicated escitalopram 20 mg, one and a half tablets should be given to Resident 10 once daily. The medication administration record (MAR) indicated potassium chloride was not given on 3/7/24 and 3/9/24 due to not being available. The documentation space pertaining to the administration of potassium for 3/8/24 was blank. The MAR indicated escitalopram was not given		**accomplished for those residents found to have been affected by the deficient practice?** Medications for affected resident received on 3/12/24 from outside pharmacy; resident has elected to utilize an outside pharmacy. Self-administration assessment completed on 3/13/24 and resident will administer her own medications going forward. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A full audit of all resident medications completed by 3/22/24 to identify any corrective action. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** Education will be provided to nursing staff related to medication error and physician notification. Communication and education will be provided to families regarding protocol for newly prescribed medications and refills. Twice weekly audits of resident medications will be completed for 4 weeks and weekly thereafter for 3 months.	

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	3/1/24, 3/3/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, 3/9/24, 3/10/24, 3/11/24. The documentation spaces on the MAR pertaining to the administration of escilaopram for 3/2/24 and 3/8/24 were blank. During an interview on 3/11/24 at LPN 3 indicated Resident 10's potassium chloride and escitalopram had been ordered from the pharmacy, but had not been delivered yet. A review of progress notes indicated no notations had been made to indicate the physician had been notified of the failure to administer the missing medications. WebMD.com indicated not giving potassium as ordered could result in heart failure. WebMD.com also indicated being without a prescribed antidepressant could lead to exacerbation of depressive symptoms. In an interview on 3/11/24 at 2:47 PM, the Director of Nursing indicated she was unable to find a facility policy pertaining to missing medication. She indicated staff should call the pharmacy to obtain medication when is not available and notify the physician of any omitted doses.		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place and** Twice weekly audits to be completed by DON or designee for 4 weeks and weekly for 3 months, monthly x 2 months. DON or designee will forward monthly audits to Executive Director and to the QAPI team for review x 6 months. QAPI committee will make recommendations if needed. **By what date the systemic changes will be completed.** 4/3/2024	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical			

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	limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview, and record review the facility failed to ensure clinical documentation pertaining to a hospital transfer was included in the medical record for 1 of 2 residents reviewed (Resident 9). Findings include: Resident 9's record was reviewed on 3/11/24 at 1:36 PM. Diagnoses included dementia, diabetes mellitus, and anxiety. A review of progress notes dated 2/14/24 at 6:00 PM indicated Resident 9 was sent to the hospital for a reason of "wellness". No description of clinical condition, indications of transfer, or any document was sent with the resident to indicate medications used, current diagnoses, diet or any other pertinent information included in the progress notes. During an interview on 3/11/24 at 1:58 PM, the Director of Nursing (DON) indicated staff should document an assessment of the resident's condition, physician's orders to send to the hospital and notifications when a resident is sent to the hospital. In an interview on 3/11/24 at 2:47 PM, the DON indicated she was unable to find a policy pertaining to transfer documentation, but she had provided a document with a list of required	R 0354	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #9 no longer resides at the community. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. Education will be provided to licensed nurses regarding transfer documentation. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** Checklist created by DON to include all required information for resident transfer. **How the corrective action will be monitored to ensure the deficient practice will not**	04/03/2024

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	documentation for her nursing staff to follow. The untitled, undated document indicated staff should complete a progress note explaining why the resident went out with notifications. She indicated the documentation guidelines should have been followed when Resident 9 was sent to the hospital.		**recur, i.e. what quality assurance program will be put in place and** DON/designee will audit resident transfers for 6 months as they occur. Audits will be reviewed monthly x 6 months by QAPI committee. QAPI will make recommendations as needed. **By what date the systemic changes will be completed.** 4/3/2024	
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure accurate documentation of a resident's condition preceding death, disposition of the resident's medications and release of the resident's personal belongings for 1 of 2 residents reviewed. (Resident 8) Findings include: Resident 8's record was reviewed on 3/11/24 at 11:50 AM. Diagnoses included coronary artery disease, lung disease and heart failure.	R 0357	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #8 no longer resides in the community. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	04/03/2024

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	A vital sign flow sheet dated February 2024 indicated Resident 8's vital signs were obtained on 2/3/24 at 6:35 P.M. A progress note indicated Resident 8's vital signs were obtained on 2/16/24 at 8:12 P.M. A progress note dated 2/19/24 at 5:21 P.M. indicated Resident 8 was showing symptoms of transition into the final stages of lung disease. The progress note indicated Resident 8 had been less responsive. The progress note indicated hospice staff had been present and the plan of care going forward had been explained. The progress note indicated Resident 8 had been comfortable and wished to follow the plan of care. The progress note did not indicate Resident 8 had been assessed. The progress note did not include Resident 8's vital signs. A progress note dated 2/20/24 at 9:14 AM indicated Resident 8's daughter believed Resident 8 had been administered too much medication and wanted the medications discontinued. The progress note did not indicate Resident 8 had been assessed. The progress note did not include Resident 8's vital signs. A progress note dated 2/20/24 at 10:02 AM indicated hospice staff had provided education to Resident 8's daughter. The progress note indicated Resident 8 had chosen hospice to manage their care. A progress noted dated 2/20/24 at 6:45 PM indicated Resident 8 had been resting quietly without apparent distress. The progress note indicated the resident displayed blood pooling in their lower legs, facial pallor and labored breathing. The progress note did not include		All residents have the potential to be affected by the deficient practice. Education will be provided to licensed nurses regarding documentation on vitals preceding death and disposition of resident, medications and belongings upon discharge. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** Checklist created by DON to verify that documentation of all information is in resident's medical record. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place and** DON/designee will audit resident discharges for 6 months as they occur. DON or designee will forward audits to Executive Director and to the QAPI team monthly x 6 months. QAPI will review and make recommendations as needed. **By what date the systemic changes will be completed.** 4/3/2024	

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	Resident 8's vital signs. A progress note dated 2/20/24 at 11:06 PM indicated Resident 8 continued to have blood pooling in their lower legs, was resting quietly and was less responsive as expected. The progress note did not include Resident 8's vital signs. A progress note dated 2/21/24 at 8:27 PM indicated Resident 8's daughter declined the resident's scheduled dose of morphine as she wanted to speak with him. The daughter indicated Resident 8 did not need medication that would make them sleepy. The progress note did not include Resident 8's vital signs or an assessment for pain. A progress note dated 2/23/24 at 4:38 PM indicated Resident 8 had displayed an abnormal breathing pattern and blood pooling in their hands. The progress note did not include Resident 8's vital signs or an assessment. A progress note dated 2/23/24 at 8:45 PM indicated Resident 8 had been nonresponsive and displayed shallow breathing at a rate of 14 breaths per minute. A progress note dated 2/24/23 at 4:30 AM indicated Resident 8 had stopped breathing and did not have a pulse at 4:35 AM. The progress note indicated the Director of Nursing, (DON) the Nurse Practitioner and the hospice provider had been notified. The progress note indicated the facility had received physician orders to release the resident to the funeral home of choice. A progress note dated 2/24/24 at 9:30 AM indicated the funeral home had arrived at the facility to pick up Resident 8's remains.			

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	In an interview on 3/11/24 at 2:00 PM, the DON indicated they were unable to locate documentation related to the release of Resident 8's belongings. The DON indicated a full resident assessment included vital signs. The DON indicated a full resident assessment should have been documented in Resident 8's record. The DON indicated they would provide the resident's hospice documentation. The DON indicated they would check with the business office for documentation of the release of Resident 8's belongings. A review of Resident 8's hospice record was conducted on 3/11/124 at 2:12 PM. A hospice sign in sheet dated 11/28/24 through 2/21/24 indicated the most recent hospice visit had been on 2/21/24. A Hospice Plan of Care Update Report dated 2/1/24 indicated Resident 8's most recent vital sign assessment had been on 1/31/24 at 11:39 AM. In an interview on 3/11/24 at 2:19 PM, the DON indicated they had provided all of Resident 8's facility and hospice documentation to the survey team. A current policy dated 2/2010 provided by the DON indicated in the event of a suspected death, the facility staff would determine level of consciousness and attempt to obtain vital signs. The policy indicated the facility staff would document the name of the funeral home the resident remains were released to as well as the release of any personal items.			