STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00206535. This visit resulted in a Partially Extended Survey-Immediate Jeopardy. Complaint IN00206535 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314. Survey date: August 3, 2016 Extended dates: August 4 & 5, 2016 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 5 Medicaid: 63 Other: 11 Total: 79 Sample: 3 Extended sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000		

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: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE 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
	16.2-3.1. QR completed by 11474 on August 5, 2016.			
F 0314 SS=J Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview and record review the facility failed to complete skin assessments for 1 of 3 residents reviewed with low risk for skin impairment. This resulted in a resident at low risk for skin impairment developing a Stage 4 pressure area with bone exposure, hospitalization and surgical debridement. (Resident #O) The immediate jeopardy began on 7-31-2016 when a resident that was at low risk for pressure areas developed a	F 0314	**1. A member of Nurse Management contacted the responsible party and the medical record regarding the pressure injury on 7/31/16. A treatment order for the pressure injury was obtained from the physician by a licensed nurse and the treatment was completed as ordered on 7/31/16. The nurse who completed the skin assessment on 7/27/16 was suspended on 8/1/16 by the Director of Nursing pending**	08/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE 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
	Stage 4 pressure area on his heel which had not been previously assessed, which resulted in hospitalization and surgical debridement. The Administrator, Director of Nursing and Signature Care Consultant were notified of the immediate jeopardy on 8-3-2016 at 3:14 PM. The immediate jeopardy was removed on 8-4-2016. Findings include: Resident #O's record was reviewed on 8-3-2016 at 11:38 AM. Resident #O's diagnoses included diabetes, high blood pressure, Alzheimer's dementia, peripheral vascular disease, and lung disease. A review of Resident #O's quarterly Minimum Data Set (MDS), dated 6-15-2016, indicated Resident #O was ambulatory with standby supervision. Further, the document indicated Resident #O's Basic Interview for Mental Status Score was 7 which indicated Resident #O had poor decision making skills and was cognitively impaired. A quarterly nursing information assessment, dated 3-17-2016, indicated Resident #O had a Braden Skin Risk score of 18. This indicated Resident #O was at low risk for pressure ulcer		**investigation. The wound was assessed by the wound NP on 8/1/16 and documented in the medical record. A licensed nurse complete wound documentation in wound sense on 8/1/16. The wound Nurse Practitioner and SCC met with the POA and daughter to discuss wound, Physician Orders and plan of treatment on 08/01/16 The care plan was unable to be revised due to the resident was discharged to the hospital on 8/1/16. Nurse Management and/or Nurse Consultant conducted interviews with care givers assigned to the resident over the last 7 days to determine root cause of incident on 8/1/16. 2. 100% skin sweep of the building was completed by Nurse Management and/or Nurse Consultant on 8/1/16. No new pressure injuries were noted. All resident care plans will be reviewed by a licensed nurse to ensure pressure injury preventative interventions have been care planned as appropriate by 8/4/16. 3. Staff education with all nursing staff regarding skin prevention interventions, including skin assessments, accurate skin assessment documentation, and documentation on shower**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE 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
	development. A care plan, dated 12-22-2015, titled risk of skin breakdown indicated the facility was to "inspect skin during bathing, especially over bony prominences. and Complete weekly skin check." A review of CNA shower sheets completed for Resident #O, between 7-18 and 7-31-2016, indicated only one skin check had been documented with the shower. A review of the Weekly Summary, dated 7-27-2016, for Resident #O indicated there were no skin conditions present. A review of Resident #O's progress notes indicated, on 7-31-2016 at 9:32 PM, Resident #O had been found with a heel wound that had a foul odor, brownish/ yellow tinged drainage, and discoloration throughout the wound bed. There were no measurements documented in the progress notes. A review of Resident #O's Weekly Skin Information, dated 7-31-2016 at 3:17 PM, indicated Resident #O had an open area on the bottom of the left foot 5 x 5.5 x 0 (length by width by depth). There was no unit of measurement or other description of the area attached to the		**sheets was completed by Nurse Management and/or Nurse Consultant on 8/4/16. Any nursing personnel that did not attend the in-service will not be allowed to work their next assigned shift until education has been provided.** **No system changes were required. The facility reviewed the Skin Procedure with the Medical Director and the Chief Medical Officer via phone on 8/2/16 and determined the process did not require any changes. The following monitoring process will be implemented to prevent further events of this type in the future. Nurse management staff will complete follow up skin assessments on 25% of the weekly skin assessments completed by licensed nurses 5 times 4 weeks to ensure accuracy; then 15% of completed skin assessments 3 times a week times 4 weeks; then 15% of completed skin assessments weekly times 2 months. Nurse management will audit 25% of newly developed care plans to ensure preventative interventions are present on care plans 5 times a week times 4 weeks; then 15% of newly developed care 3 times a week times 4 weeks; then 10% of newly developed care plans monthly times 3**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/05/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE 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
	report. A review of the progress notes, dated 8-1-2016 at 2:44 PM, indicated the family wanted to send Resident #O to the hospital for evaluation of the foot wound. A review of Resident #O's Emergency Room notes, dated 8-1-2016, indicated the foot wound was Stage 4 (according to the National Pressure ulcer Advisory Panel,a Stage 4 wound is one with full thickness skin and tissue loss with exposed bone, muscle, tissue or ligaments.) and located on the left heel. The report further indicated Resident #O was well nourished, and in no apparent distress. The left foot was noted to be brightly reddened, with a 4 cm (centimeters) in diameter open wound on the lateral aspect of the heel with purulent eschar around the edges. There was no depth noted in the Emergency Room report. A photo of Resident #O's heel had been taken by the resident's step daughter on 8-1-2016 at approximately 5 PM. It was shared and indicated the area was open on the bottom of the foot at the heel area with white irregularly shaped edges surrounding the the open wound. The wound itself had a maroon colored area about 1/3 the way around the exposed		**months. Nurse management will review completed shower sheets during the clinical meeting (M-F) to identify any potential skin issues that need to be addressed.** 4. **A QAPI meeting will be conducted with the Medical Director via phone by the IDT members on 8/3/16 to discuss investigation and survey findings. QAPI meetings will be conducted weekly times 4 weeks; then resume monthly if compliance is maintained. Audit findings will be discussed and the action plan revised as needed to maintain compliance.** **Upon completion of the plan of correction, no other residents were affected as evidence by the facilities skin sweep. The facility requests an IDR due to the evidence that no further residents were affected along with the ongoing monitoring that is currently in place.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE 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
	bony area which appeared to be about the size of a nickel. It appeared to be rough on the surface in the 6 o'clock to 10 o'clock positions, in the 1 o'clock to the 4 o'clock position next to the bone, the white area appeared as light greenish blue. The whitened area around the open area appeared to extend up the back of the heel about an inch. In an interview on 8-3-2016 at 1:45 PM, LPN #3 indicated Resident #O had been experiencing swelling in his feet, and in March, the family changed his tennis shoes for hard soled non-skid slippers. LPN #3 further indicated Resident #O sat leaning forward with his elbows on his knees and scooted his feet forward and backward while he was seated. In an interview on 8-3-2016 at 10:43 AM, CNA #1 indicated the nurse did not always do her skin checks when she was supposed to, even after the CNA told the nurse the resident was ready to have the skin check completed. In an interview on 8-3-2016 at 10:50 AM, Resident #T indicated sometimes the nurse would come in the shower and talk, but not really look at her skin. In an interview on 8-3-2016 at 10:35 AM, LPN #2 indicated the CNAs were to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE 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
	tell the nurse when the shower was completed, and the nurse was to check the resident's skin condition. A current undated policy titled Skin Assessments and Evaluations provided on 8-3-2016 at 11:49 AM by the Corporate Nurse indicated "10. Licensed Nurses,...must complete and document all weekly skin assessments....." On 8-4-2016 at 2:20 PM, the Signature Care Consultant provided a document titled Allegation of Compliance dated 8-3-2016. The document indicated the facility had completed a 100% skin sweep of current resident skin condition on 8-1-2016. The document further indicated all resident care plans had been reviewed to ensure pressure injury prevention interventions were properly care planned on 8-4-2016. Additionally, the document indicated staff reeducation regarding skin prevention interventions, including skin assessments, accurate skin assessments, accurate skin assessment documentation, and documentation on shower sheets was completed on 8-3-2016. Nurse staff that did not attend the inservice would be reeducated prior to working their next assigned shift. Monitoring was outlined as follows: nurse management would complete follow up skin assessments on 25% of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE 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
	weekly skin assessments; audit 25% of new developed care plans to ensure preventative interventions are present on care plans; and review completed shower sheets during clinical meeting to assist with any potential skin issues. Observations of resident skin on 8-3-2016 indicated residents had clear skin, or any area that was observed on a resident had been identified, matched the identified description, and was receiving treatment. Care plans reviewed on 8-3, and 8-4-2016 indicated pressure prevention interventions were in place according to the plan of care. Observations indicated nursing staff were being reeducated prior to the next shift worked and at formally scheduled inservices. According to interviews with selected staff, on 8-4 and 8-5-2016, staff were able to verbalize what to look for when doing a skin assessment and were able to verbalize if there was a question someone had completed an assessment to inform their superiors. Nurse management was observed reviewing care plans, skin assessments, and shower sheets on 8-5-2016. The immediate jeopardy that began on 7-31-2016 was removed on 8-4-2016 when the facility completed reeducation of nursing staff on skin prevention			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE 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
	interventions, including skin assessments, skin assessment documentation, and shower sheet documentation, but the non compliance remained at a lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all employees had not been reeducated and monitoring was not completed. This Federal Tag is related to Complaint IN00206535. 3.1-40(a)(1)			