STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155255	A. BUILDING 00 B. WING	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00387391. Survey dates: August 9, 10, 11, 12, and 15, 2022 Facility number: 000158 Provider number: 155255 AIM number: 100291490 Census Bed Type: SNF/NF: 55 NCC: 5 Total: 60 Census Payor Type: Medicare: 3 Medicaid: 54 Other: 3 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 16, 2022	F 0000	This Plan of Correction constitutes this facility's 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. This Plan of Correction is submitted to meet requirements established by state and federal law; or – Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this			

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	section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure the MDS (Minimum Data Set) was acurately completed for 1 of 1 resident reviewed (Resident 257). Findings included: A review of Resident 257's record on 8/11/2022 at 8:45 AM, indicated diagnoses included end stage renal disease, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, hyperlipidemia, unspecified, and muscle weakness (generalized). A physician order dated 7/26/22, indicated to maintain a Foley catheter size 16 fr (French) with a 10 ml (milliliter) balloon for a diagnosis of neurogenic bladder. An MDS dated 7/27/22, was reviewed. Section H assessed bladder and bowel. Under the appliances section, the indwelling catheter was not selected for the resident. The MDS did not indicate Resident 257 had a catheter. In an interview on 8/11/22 at 9:53 AM, the MDS coordinator indicated Resident 257 had a Foley. She indicated there was not a MDS for the catheter, but there should have been.	F 0636	Deficiency ID: F 636 SS=D Date of Completion: August 24, 2022 1. It is the intent of the facility to ensure that the MDS is accurately completed for each resident that resides at the facility. One resident didn't meet this requirement. The resident no longer resides at the facility. 2. An audit of MDS accuracy was performed by the MDS Coordinator on all MDS assessments for current residents residing in the facility. The audit will be ongoing for all new residents admitted to the facility. Attachment #1. 3. An in-service was performed with the MDS Coordinator on the importance of all MDS assessment to be accurate according to the resident and the RAI manual specified by CMS. Attachment # 2	08/24/2022

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	A current facility policy, Resident Assessment, was provided by the Administrator on 8/11/22 at 111:39 AM. The facility policy indicated... " A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirement...A "comprehensive assessment" includes: a. Completion of Minimum Data Set (MDS). B. Completion of Care Area Assessment (CAA) process; and C. Development of the comprehensive care plan...." 3.1-31(d)		4. The MDS Coordinator/designee will assure that Audits will be performed with every new admission X 6 months to assure that all requirements for the residents MDS accuracy. This will be addressed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. It is the intent of the facility to assure 100% compliance with regulations. See attachment #3.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).			

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	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure care plans were completed for 1 of 1 resident reviewed. (Resident 257). Findings include: A review of Resident 257's record on 8/11/2022 at 8:45 AM, indicated diagnoses included end stage renal disease, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, hyperlipidemia, unspecified, and muscle weakness (generalized). A physician order dated 7/26/22, indicated to maintain a Foley catheter size 16 fr (French) with a 10 ml (milliliter) balloon for diagnosis of neurogenic bladder. A care plan dated 8/3/22, was reviewed. There was not a care plan for urinary foley catheter with a	F 0656	Deficiency ID: F 656 SS=D Date of Completion: August 24, 2022 1. It is the intent of the facility to ensure that the facility will develop/implement care plans that are accurately completed for each resident. One resident didn't meet this requirement. She no longer resides at the facility. 2. An audit of Care Plans was performed by the MDS Coordinator and is ongoing for the residents that are currently in the facility and will be audited for new residents admitted to the facility. #1 3. An in-service was performed with the MDS Coordinator and the nursing staff. This was to assure the MDS Coordinator and nursing	08/24/2022

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	focus, goal and interventions. In an interview on 8/11/22 at 9:53 AM, the MDS (Minimum Data Set) coordinator indicated Resident 257 had a Foley. She indicated there was not a care plan for the catheter, but there should have been. A current facility policy, Comprehensive Assessment and the Care delivery Process, dated 2001, was provided by the Administrator on 8/11/22 at 11:39 AM. The policy indicated ..." Comprehensive assessment will be conducted to assist in developing person-centered care plans ...Comprehensive assessments, care planning, and the care delivery process involve collecting and analyzing information, choosing and initiating, interventions and then monitoring results and adjusting interventions ...." 3.1-35(a)		staff will create accurate care plans for all residents according to the RAI manual specified by CMS. #2 4. The MDS Coordinator/designee will assure that Audits will be performed with every new admission X 6 months to assure that all requirements for the residents care plan are accurate. This will be addressed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. It is the intent of the facility to assure 100% compliance with regulations. #3.	