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	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT FORT WAYNE WEST	611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00433376. Complaint IN00433376: No deficiencies related to the allegations are cited. Survey dates: May 6 and 8, 2024 Facility number: 011804 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 9, 2024	R 0000	The submission of this Plan of Correction does not indicate an admission by StoryPoint Fort Wayne West that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of StoryPoint Fort Wayne West. The community hereby maintains it is in compliance with the requirements of participation for residential health care communities. StoryPoint Fort Wayne West respectfully requests the best review for paper compliance.	
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 site at all times. Residential facilities with over one hundred (100) residents regularly			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Daugherty	Administrator	05/24/2024

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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	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 a cardiopulmonary resuscitation (CPR) and first aid certified staff member was on duty for 7 of 7 days reviewed. Findings include: During a record review conducted on 5/7/24 at 10:16 AM, staffing records from the period of 4/30/24 to 5/6/24 were reviewed. On 4/30/24, no first aid certified staff member was present between 5:00 PM and 10 PM. No CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/1/24, no CPR or first aide certified staff member was present between 5:45 PM and 6:00 AM. On 5/2/24, no CPR or first aide certified staff member was present between 7:15 PM and 10:00 PM. On 5/3/24, no CPR or first aide certified staff member was present between 5:00 PM and 6:00 AM. On 5/4/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM.	R 0117	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No resident was affected by the alleged deficient practice. What measures will be put in place or what systemic changes will the faciity make to ensure the deficient practice does not recur? A 12-month notebook will be maintained. All licensed nurses and QMA's will be given a 30-day reminder to renew their CPR credentials. A second reminder will be given 15 days prior to expiration. If they do not provide proof of the renewal, they will be removed from the schedule until they can provide proof that their credentials are current. Department directors will be made aware of the pending suspension. The wellness scheduler will report to the administrator and QA Committee at the last meeting of the month of any credentials expiring in the following month.	06/07/2024

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	On 5/5/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/6/24, no CPR or first aide certified staff member was present between 5:00 PM and 6:00 AM. During an interview on 5/7/24 at 12:10 PM the Director of Nursing 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. A current facility policy titled Staffing Requirements, dated 2/21/23, provided by the Director of Nursing on 5/8/24 at 2:06 PM indicated a minimum of one awake staff member with CPR and first aid certification should be always present on site.		Each department director will be made aware of any employees who may need to be removed from the schedule if they are not in compliance by the required date. The Administrator will monitor for 6 months to ensure practice is being followed.	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review the facility failed to ensure certification was maintained for 3 of 47 employee certifications reviewed {Home Health Aide (HHA) 21, Qualified Medicine Aide	R 0118	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents may have been	06/07/2024

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	(QMA) 22, and Certified Nurse Aide (CNA 23)}. 103 residents resided in the building. Findings include: During a record review beginning 5/8/24 at 10:16 AM, HHA 21 did not have a current certification on file at the facility. A Demographic Information form presented by the Director of Nursing (DON) on 5/8/24 at 2:06 PM indicated HHA 21 certification expired on 9/9/23 and was classified as non-renewable due to being expired for too long. A Demographic Information form presented by the DON on 5/8/24 at 2:06 PM indicated QMA 22's certification expired on 5/7/24. A Demographic Information form presented by the DON on 5/8/24 at 2:06 PM indicated CNA 23's certification expired on 5/7/24. A review of nursing department schedules from 4/30/24 to 5/8/24 indicated HHA 21 was on duty on the assisted living unit on 4/30/24, 5/1/24, 5/2/24, and 5/8/24. QMA 22 worked from 10:00 PM 5/7/24 to 6:00 AM on 5/8/24 overseeing medication needs for the facility on all units. In an interview on 5/8/24 at 12:10 PM, The Director of Nursing (DON) indicated licenses and certifications were checked upon hire and audited monthly thereafter. She indicated she was unaware of the expired certifications. She indicated HHA 21, QMA 22, and CNA 23 were on the current schedule for 5/8/24, and she would remove them immediately. She indicated audits had not been occurring as they should have been. A current policy titled Staffing Requirements		affected by thi deficient practice. All licenses, certified or qualified employee licenses have been reviewed to ensure their credentials are active and in good standing with the Indiana Department of Health. If an employee was not current, they were suspended immediately until their status is returned to good standing. 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? As all residents had the potential to be affected; there were no other residents affected by this practice. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not reoccur. A 12-month binder will be maintained with each employees' credentials expiration dates. Employees will be given a 30-day reminder to get their credentials renewed and final notice will be given two weeks prior to the renewal deadline. Employees who do not provide proof of this being completed will be removed from the schedule until they can provide proof of renewal. Department directors will be made aware of those who need to get their credentials renewed.	

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	dated 2/21/23 provided by the DON on 5/8/24 at 2:06 PM indicated any unlicensed staff providing more than limited assistance must be a CNA or HHA and QMAs must have proof of certification. The policy indicated the community must verify the status of any license or certification.		The wellness scheduler will be reporting to the Administrator and the QA Committee at the last wellness committee meeting of the month for the credentials expiring in the upcoming month. Each Department head will be made aware of their employee's timeline to assist in holding accountability. The Administrator will monitor the compliance monthly for six months.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review the facility	R 0123	What corrective action(s) will be	06/07/2024

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	failed to ensure current and accurate employee files were maintained for 3 of 5 employee files reviewed. Findings include: In a review of employee files on 5/8/24 at 10:16 AM a health screening was not found in the file for Maintenance Technician 24. The file for Server 25 did not include a health screening, tuberculosis testing, general orientation and job specific orientation, a job description, or training in resident rights, abuse, or dementia. The file for the Executive Chef did not include a health screening, general and job specific orientation or a job description. In an interview on 5/8/24 at 12:10 PM, the Director of Nursing indicated employee files should be current and complete. She indicated orientation to the facility and department and job descriptions are necessary for new staff to understand job expectations. She also indicated staff should have documentation of tuberculosis testing and documentation they are healthy enough to perform their job duties. She indicated employee files should be audited to ensure all orientation and hiring documents have been completed. She indicated she did not have any further employee file documents available for review. A current policy titled Employee File Audit, undated, provided by the Administrator on 5/8/24 at 1:58 PM indicated employee files should include a job description, training in abuse/neglect, resident rights, and dementia care, tuberculosis skin testing results and health		accomplished for those residents found to have been affected by the deficient practice: All residents may have been affected by this deficient practice. All employees' personnel files have been reviewed and have the required paperwork. 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? The community realizes that all residents could have been affected by the alleged deficient practice. All employees' personnel files have been reviewed and updated. All new employee files will be audited regularly to ensure the proper paperwork is present. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur. A twelve-month notebook with tabs for each month will be maintained. All employees will be given a 30-day reminder to renew any required paperwork and with 15 days (about 2 weeks) second notice will be given to those individuals advising they will be	

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	screenings.		removed from the work schedule if paperwork is not updated in the allotted timeframe. These employees will not be able to work until all the paperwork is completed. The departmental directors will also be made aware of the pending suspension. The Property Administrator will be reporting to the Administrator and the QA Committee at the last Wellness Committee meeting of the month for an annual review of required paperwork for the coming month. Each Department/Lead will be made aware of their employee's timeline also. Employees failing to complete the required paperwork will be removed from the schedule until they are in compliance. The Administrator will monitor for compliance monthly for the next six months.	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to ensure 4 of 8 pets living with residents in the facility had their required immunizations. Findings include:	R 0151	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	06/07/2024

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	During an interview and review of veterinary records provided by the Administrator on 5/8/24 at 10:04 AM. indicated documents contained veterinary visit and vaccination records for each pet residing in the facility. He indicated 4 pets living in the facility were not up to date on their vaccinations. 1.A veterinary record for a male cat belonging to Resident 10 dated 4/22/22 indicated no vaccination records were available for Resident 10's male cat. No additional records for Resident 4's male cat were available for review. 2. A veterinary record for a female cat belonging to Resident 10 dated 3/5/20 indicated no vaccination records were available for Resident 10's female cat. No additional records for Resident 4's female cat were available for review. 3.A veterinary record for a cat belonging to Resident 11 indicated the cat received a rabies vaccine on 3/14/22. The record indicated the rabies vaccine should be repeated by 3/14/23. The record indicated a wellness visit was due by 3/14/23. No additional records for Resident 11's cat were available for review. 4. A veterinary record for a cat belonging to Resident 12 indicated the cat received a rabies vaccine on 9/16/19. The record indicated the rabies vaccine should be repeated by 9/16/20. No additional records for Resident 12's cat were available for review. A review of the current facility policy, titled Pet Policy, last reviewed 4/5/21, provided by the Director of Nursing on 5/8/24 at 12:03 PM, indicated pets must submit to an annual health		All residents may have been affected by this deficient practice. All pets will have their required paperwork on file in the front office and must be current on all immunizations. 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? Since all residents had the potential to be affected; there were no other residents affected by this practice. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All pets residing in the community are current on Vet visits and immunizations. All visiting pets will also have their records on file prior to visiting the community. Monthly the receptionist will notify residents at least 30 days in advance that their pet records for vaccinations and or visits will be expiring. If the pet owner does not provide updated records the pet will be removed from the community. The Property Administrator will inform the QA team at the last meeting of the	

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	record and be registered and vaccinated in accordance with applicable local laws and requirements.		month of the status of all pets. Pets not incompliance with the rules will be removed from the community until they are in compliance. The Administrator will monitor for compliance monthly for the next six months.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or			

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	both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review the facility failed to ensure a current, signed service plan was completed for 3 of 5 residents reviewed (Resident 5, Resident 6, and Resident 8). Findings include: 1.Resident 5's record was reviewed on 5/6/24 at 1:30 PM. Diagnoses included unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, arthritis, and essential hypertension. Resident 5's current service plan, last revised 2/12/24, did not contain resident or representative signatures. Documentation of any review of the service plan with Resident 5 or her representative was not available for review. 2. Resident 6's record was reviewed on 5/6/24 at 2:21 PM. Diagnoses included depression, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and essential hypertension. Resident 6's current service plan, dated 9/2/23 with a goal date of 2/29/24 contained the Director of Nursing's (DON) signature dated 9/5/23 and Resident 6's representative's signature dated 9/7/23. No additional service plans for Resident 6 were available for review. 3.Resident 8's record was reviewed on 5/8/24 at 11:20 AM. Diagnoses included unspecified dementia, unspecified severity, behavioral	R 0217	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Service Plans for residents 6 and 8 have been updated. 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? The community realizes that residents could have had the patient to be affected by the alleged deficient practice. An audit was completed to ensure all other residents' Service Plans are within the six-month time requirement. All residents with a time greater than six months will have a new Service Plan. A calendar has been established to ensure reviews are completed in a timely manner. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The Wellness Director will review the calendar to track the	06/07/2024

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	disturbance, psychotic disturbance, mood disturbance, and anxiety, hypothyroidism, unspecified, and vitamin d deficiency. Resident 8's current service plan, dated 12/12/23, did not include Resident 8 or his representative's signatures. Documentation of any review of the service plan with Resident 8 or his representative was not available for review. In an interview on 5/8/24 at 12:12 PM, the DON indicated service plans should be up to date, signed and dated by the resident or representative and facility staff. A current policy titled Resident Evaluation and Service Plan dated 2/24/23 provided by the DON on 5/8/24 at 12:03 PM indicated Service Plans should be completed upon admission and every 6 months thereafter. The policy indicated a current service plan should be reviewed and signed by staff and the resident or their representative.		6-month requirement. The Wellness Director will present the list of service plans needing updated to the Wellness Committee at Wellness Meeting weekly for 1 month and then will present the services plans needing updated to Wellness Committee at the last meeting of each month thereafter. The Administrator will monitor compliance for the next six months.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure labeling of foods, maintian cleanliness of the kitchen, and equipment. 103 residents ate food prepared in the kitchen. Findings include: During a tour of the kitchen with the Executive Chef on 5/6/24 beginning at 9:20 AM a	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No resident was affected by the alleged deficient practice. How will the facility identify other residents having the potential to	06/07/2024

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	handwashing sink was observed to be soiled with a pea sized clump of red gelatinous material stuck to the inside of the sink bowl. A trash can was observed next to the handwashing sink. The lid of the trash can was observed to be soiled with a thin, brown film. There was pea sized, dry, green, leafy material observed on the trash can lid. The Executive Chef separated 3 stacks of steam table pans stored on shelves. Moisture was observed on the inside of 3 pans. A dime sized, wet, leafy green material was observed on the inside of 1 pan. A half full open gallon of milk was observed to have no open date. 3 small plates of fruit were observed to have no open date. A large bowl of leftover cold salad was observed to have no open date. A plastic container of strawberries was observed to have no open date. The Executive Chef indicated all opened food items should be labeled with the date the items had been opened. A small freezer was observed to be soiled with a thin, brown film. 4 opened bags were observed inside the freezer. 3 of the 4 opened bags were observed to have no open dates. 3 of the 4 bags were observed to have labels and expiration dates. 1 of the 4 opened bags was observed to have no label, no open date and no expiration date. A deep fryer was observed next to the small freezer. The deep fryer grease was black. The deep fryer grease contained brown and black items floating on the surface of the grease. The outside of the deep fryer was coated in a yellow and brown substance. The floor under the deep fryer was coated with a yellow and brown substance.		be affected by the same deficient practice and what corrective action will be taken? The culinary cleaning check list was re-implemented, and employees were in serviced on proper technique and sanitation standards. The Executive Chef will check cleaning logs weekly. The Executive Director will check logs weekly to ensure compliance until in compliance for 2 months in a row, then will check every 2 weeks for one month and then monthly moving forward	

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		A. BUILDING 00 B. WING	05/08/2024

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	The wall behind the deep fryer was coated with a yellow and brown substance. The Executive Chef indicated the deep fryer was cleaned every Wednesday. The Executive Chef indicated the deep fryer grease was changed every Wednesday. A blank cleaning log was observed hanging on the wall. The Executive Chef indicated the deep fryer was not included on the cleaning log. The outside dumpster area was observed to be littered with cigarette packs, cigarette butts and fast-food wrappers. The Executive Chef indicated there should not be trash on the ground in the dumpster area. In an interview on 5/6/24 at 9:45 AM, Cook 20 indicated the trash cans had lids but the lids were usually kept elsewhere. 3 trash can lids were observed between a storage shelf and a wall. Cook 20 indicated they were unaware of how often the deep fryer was cleaned. Cook 20 indicated they were not familiar with the use of a cleaning log. In an interview on 5/8/24 at 11:32 AM the Director of Nursing (DON) indicated they were unable to locate a policy related to kitchen sanitation. An undated current facility policy provided by the DON on 5/8/24 at 11:32 AM indicated all perishable food items must be labeled with an open date and an expiration date. The policy indicated the label must include the name of the item, the open date, the expiration date and the initials of the employee.			
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning			

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	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 resident condition prior to death, disposition of resident remains and disposition of personal belongings for 2 of 2 residents reviewed (Resident 4 and Resident 7). Findings include: 1.Resident 4's record was reviewed on 5/6/24 at 10:40 AM. Diagnoses included hypertension, unspecified dementia, and abnormal weight loss. A progress note dated 2/18/24 at 8:25 PM indicated Resident 4's vital signs were assessed, and the resident was not in distress. A progress note dated 2/19/24 at 9:45 AM indicated Resident 4 was not breathing, did not have a pulse and did not have a blood pressure. Resident 4's son and hospice provider were notified. A progress note dated 2/19/24 at 1:50 PM indicated the funeral home had picked up Resident 4's remains. There were no notes to indicate Resident 4's condition prior to death. There was no documentation to indicate disposal of Resident 4's personal belongings.	R 0357	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this alleged 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? The community realizes that other residents could have had the patient to be affected by the alleged deficient practice. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The Wellness Director will review all documentation regarding the decline of residents and the disposition of their belongings after the resident has expired. The Wellness Director will present the	06/07/2024

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	2. Resident 7's record was reviewed on 5/8/24 at 9:29 AM. Diagnoses included unspecified dementia, anxiety and major depressive disorder. A progress note dated 4/9/24 at 11:27 AM indicated Resident 7 had slid from their chair onto the floor. Resident 7 did not have injuries. A progress note dated 4/20/24 at 5:37 PM indicated Resident 7 was not bearing weight, had reported having pain and had voiced that they wanted to die. A progress note date 4/20/24 at 11:00 PM indicated Resident 7 had a right hip fracture. A progress note dated 4/24/24 at 12:10 AM indicated Resident 7 was not breathing, did not have a pulse and did not have blood pressure. Resident 7's hospice provider was notified. This progress note was the last entry in Resident 7's record. There was no note to indicated Resident 7's condition prior to death, the disposition of their remains, or the disposition of their personal belongings. In an interview on 5/8/24 at 10:05 AM the Executive Director (ED) indicated resident condition prior to death and the release of resident remains should have been documented in the record. The ED indicated the business office handled resident personal belongings. In an interview on 5/8/24 at 10:10 AM, the Director of Nursing (DON) indicated documentation should have included the resident's condition prior to death and the release of resident remains.		list of her findings to the Wellness Committee at the last Wellness Meeting of the month concerning any deaths during that month and since the last QA meeting. The Administrator will monitor compliance after every death for the next six months.	

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	The DON indicated the facility did not have a policy related to the release of personal belongings. The DON indicated the business office handled move out operations and did not keep a record of personal belongings. A current facility policy dated 9/20/22 provided by the DON on 5/8/24 at 9:30 AM indicated in the event of a hospice client's death, the facility should contact hospice and follow the hospice nurse's direction on the next steps. The policy did not address documentation or the disposition of personal belongings.			