STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00357027 Complaint IN00357027 - Unsubstantiated due to lack of evidence Survey dates: July 27, 28, 29, 30 and August 2, 2021. Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 1 Medicaid: 67 Other: 23 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed Auguet 3, 2021	F 0000		
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observation, interview, and record review the facility failed to act on grievances in a timely manner for 11 of 13 residents who reside in the facility. Findings include:	F 0565	**F 565 E Resident/Family Group and Response** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or	08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident council minutes dated 2/8/21-7/14/21 were provided by the Administrator on 7/28/21 at 10 AM. The resident council minutes indicated in May, June and July 2021 the residents had concerns of food running out during meals and not receiving the food they had ordered. A resident council meeting was conducted on 7/28/21 at 1:30 PM, 13 members were in attendance. During the meeting 11 of 13 members indicated they were not getting food they ordered from the menu or the kitchen was running out of food and serving something else. Grivance forms are filled out during Resident Council, but the residents had not gotten resolution. Resident 62 indicated on 7/28/21, the kitchen ran out of peas and served carrots instead, had complained about substitutions prior to now, but had not had any resolution. An observation was made on 7/30/21 at 12:44 PM, the Social Service designee asked Resident 54 if he would like alternative to his meal. Resident 54 requested a hamburger. The Social Service Designee provided Resident 54 with a grilled cheese and indicated the kitchen was out of hamburgers, so the residnet could not obtain the meal requested. An observation was made on 7/30/21 at 12:53 PM, Resident 6's meal tray sheet indicated a magic cup should be served with all meals. Resident 6 did not have a magic cup on her tray. The CNA assisting Resident 6 was interviewed on 7/30/21 at 12:53 PM. She indicated the kitchen ran out of magic cups. The CNA also indicated Resident 6 usually consumes a magic cup at all meals.		execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1.) Immediate action taken for those residents identified:** Interviews were conducted with resident #62, #54 and #6 to determine that their grievances had been addressed to their satisfaction. **2.) How the facility identified other residents:** A resident council meeting was held to determine if there were any concerns that had not been addressed. Identified issues were immediately addressed. **3.) Measures put into place/ Systemic changes:** Facility Staff were educated on the Grievance Policy. Concerns/grievances will be reviewed during scheduled departmental meetings to determine prompt actions were taken regarding any grievance. Any issues identified will be immediately corrected per Executive Director. Bi-monthly resident council meetings times 3 months to ensure timely follow up is occurring and residents express	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The Regional Dietary Manager was interviewed on 7/30/21 at 1:38 PM. She indicated the kitchen ran out of meat (pork loin) on 7/28/21. On 7/29/21 the kitchen ran out of peas and 2 residents had to be served carrots. On 7/30/21, the kitchen ran out of magic cups and health shakes were offered as a substitute. She indicated residents should be able to get what is served and ordered. The Activity Director was interviewed on 8/2/21 at 12:36 PM. The Activity Director indicated when a resident had a grievance/concern during a Resident Council meeting, the Activity Director would fill out a resident council follow up form and give the form to the specific department. The Activity Director also indicated she was aware of the food concerns. She had given the monthly follow up forms for May, June and July 2021 to the Dietary Manager and Administrator but had not gotten a response back. The Administrator was interviewed on 8/2/21 at 12:53 PM. He indicated he was aware the kitchen ran out of food on 7/28/21. The Administrator also indicated everyone should have their grivances resolved. A policy was provided by the Adminsitrator on 8/2/21 at 1:22 PM, titled "Client Complaints & Grievances." The policy indicated all complaints/grievances shall be addressed immediately and steps shall be taken to resolve the issue. 3.1-3(l)		satisfaction with outcomes. Grievances will be recorded on facility grievance forms and indicate the steps taken to resolve the issues, signatures of the department managers responsible for follow up, and Executive Directors signature and date verifying completion. **4.) How the corrective actions will be monitored:** Executive Director or designee will audit resident council notes and grievance forms weekly assure verification of resident concerns and grievance follow through. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Date or Correction- 8-23-21	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review the facility failed to ensure physician's orders were followed for 2 of 5 residents reviewed (Resident 39 and Resident 31). Findings include: 1. The clinical record for Resident 39 was reviewed on 7/29/21 at 11:25 AM. Diagnoses included, but were not limited to, type 2 diabetes with diabetic chronic kidney disease, nausea, dietary counseling and surveillance, and tracheostomy. Physician's orders dated 6/16/21, indicated Resident 39's meal consumption at breakfast, lunch, and dinner should have been recorded in the point of care task area. A Point of Care History Report dated 6/1/21 to 7/30/21 was provided by the Director of Nursing on 7/30/21 at 3:57 PM. The Point of Care History Report indicated Resident 39's meal intakes were not recorded on the following dates and mealtimes; 6/17 breakfast; 6/18 breakfast, lunch, dinner; 6/19 breakfast and dinner; 6/20 lunch; 6/21 breakfast and lunch; 6/23 lunch and dinner; 6/24 breakfast and lunch; 6/25 dinner; 6/26 breakfast, lunch, and dinner; 6/27 breakfast and dinner; 6/28 breakfast; 6/29 breakfast; 7/2 breakfast, lunch and dinner; 7/3 dinner; 7/4 breakfast; 7/8 breakfast and lunch; 7/11 dinner; 7/14 lunch; 7/15 dinner; 7/17 breakfast, lunch and dinner; 7/18 dinner; 7/19 dinner; 7/20 lunch and dinner; 7/21 dinner; 7/21 breakfast and dinner; 7/25 breakfast; 7/26 breakfast and dinner; 7/27 dinner; 7/28 dinner; and 7/29 dinner.	F 0658	**F 658D Services Provided Meet Professional Standards** **The facility requests paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1.Immediate actions taken for those residents identified:** Residents #31physician was notified regarding weight. Nursing staff were educated physician notification, following physician orders and accurate documentation. Resident #39 meals were recorded. Both residents were reviewed per facility dietician. Recommendations were reviewed and any issues identified were addressed. Physician orders	08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The Dietitian was interviewed on 7/30/21 at 2:25 PM. During the interview the Dietitian indicated she reviews Resident 39's meal intakes to determine if dietary changes need to be made and that many of Resident 39's meal intakes had not been recorded. The DON was interviewed on 8/2/21 at 12:05 PM. During the interview the DON indicated Resident 39's breakfast, lunch, and dinner meal intakes should have been recorded daily according to the physician's order and they had not been. A policy, dated 4/14/21, was provided by the DON on 8/2/21 at 11:42 AM, titled "Charting and Documentation." The policy indicated "Services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the residents medical record." 2. On 7/29/21 at 2:07 P.M., Resident 31's record was reviewed. Diagnosis included, but were not limited to, heart failure and edema. The Physician's Order dated 3/12/18, indicated the resident's weight should have been obtained every day and the physician should had been notified of a weight gain of 2 pounds (lbs) in 1 day or a weight gain of 4 lbs in 5 days. An order dated 11/25/20, indicated Resident 31 received lasix (a diuretic) 40 milligrams two times a day. Resident 31's June 2021 Treatment Administration Record (TAR) indicated the following: On 6/1 the resident weight was 284 lbs, on 6/2 the weight was 286.8 lbs. The resident's weight had increased by 2.8 lbs, but the physician had not been notified. On 6/8 the weight was not documented as done. On 6/9 the weight was 276.6 lbs, and on 6/10 the		were reviewed and updated as required and care plans were revised if indicated. **2.How the facility identified other residents:** Any current residents had the potential to be affected. Audit was conducted ensure meal consumption records were completed and physician orders requiring specific notification were followed. No resident was identified to have been affected. **3) Measures put into place/ System changes:** Education provided to Licensed Nursing Staff on physician notification and following physician orders. Education to nursing staff regarding documentation requirements for services provided, changes of condition, and documentation in the clinical record. **4.) How the corrective actions will be monitored:** The responsible party for this plan of correct will include the Director of Nursing/Designee. Audits will be conducted for 5 residents three times weekly to determine completion of meal consumption records. Those residents with specific notification orders related to weight gain or loss will be audited three times weekly for notification	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	weight was 284.2 lbs. The resident's weight had increased by 7.6 lbs., but the physican had notifed. on 6/21 the weight was not documented as done. On 6/23 the weight was 274.7 and on 6/24 the weight was 276.8 lbs. The resident's weight had increased by 2.1 lbs., but the physician was not notified. On 6/28 the weight was 278.8 lbs. On 6/29 the weight was not documented as done. On 6/30 the weight was 281.2 lbs the weight had increased by 2.4 lbs., but the physician had not been notified. There was no documentation Resident 31's Physician had been notified of increased weights as ordered. On 8/2/21 at 3:30 P.M., the Director Of Nursing provided a policy titled Medication and Treatment Orders dated 2001 and revised on 1/2014. The policy did not indicate physician's orders should be followed. On 8/2/21 at 3:27 P.M., in an interview, the Assistant Director Of Nursing indicated she had found no documentation Resident 31's Physician had been notified of the increased weights. 3.1-35(g)(1)		compliance. Review of the 24-hour report during scheduled clinical meeting for any change of condition that requires notification. Results of audits will be during daily stand-up meetings as well as reviewed in Quality Assurance Meeting monthly for 6 months or until 90% (or greater) compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **8-23-21**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review the facility failed to ensure an open area was assessed and the physician notified for 1 of 2 residents reviewed (Resident 188). Findings include: The record for Resident 188 was reviewed on 7/29/21 at 11:25 AM. Diagnoses included pressure ulcer of sacral region, spina bifida, pressure ulcer of left heel, and need for assistance with personal care. A Minimum Data Set (MDS) assessment dated 3/11/21, indicated Resident 188 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). During a continuous wound care observation with Licensed Practical Nurse 3 (LPN) and LPN 4 on 7/30/21 from 10:12 AM to 10:38 AM, the following was observed: there was an area on Resident 188's left front ankle about 2 inches long by 4 inches wide, the area had no depth. The area had a dark red dried substance on and around the area. Resident 188 was interviewed during the observation. Resident 188 indicated she had had the area on her left front ankle for a couple of weeks and it was from wearing booties. She did not indicate the bootie strap was too tight. LPN 4 was interviewed during the observation. LPN 4 indicated Resident 188 had the area on her left front ankle for a couple of weeks. LPN 4 indicated they had been putting an abdominal pad on for a while, but they had not been putting	F 0684	**F 684 Quality of Care** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those residents identified:** Resident # 188 was assessed and documented, physician notified, orders and treatment reviewed and revised as indicated, and care plan revised to reflect resident status. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. Skin sweep was completed to identify any unidentified skin conditions. Treatment Orders were reviewed, and care plans were updated as needed. Any new identified issues were reported to primary physician for review. **3) Measures put into place/ System changes:**	08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	anything on it lately including medication or anyrhing to reduce the irritation from the bootie strap. LPN 3 was interviewed on 8/2/21 at 10:44 AM. During the interview LPN 3 indicated the area to Resident 188's left front ankle had been there since she came back from the hospital. A nurse's progress note dated 7/26/21, indicated Resident 188 had returned from the hospital and had an area to her coccyx, left heel, and 3 stiches to her outer left heel. The note did not indicate an area on the left front ankle. There was no documentation from the facility Resident 188 had an area on her left front ankle or that the area had been assessed. There was no documentation the physician had been notified of the area on Resident 188's left front ankle. Unit Manager/LPN 1 was interviewed on 8/2/21 at 11:55 AM. Unit Manager/LPN 1 indicated the physician should have been notified of the area on Resident 188 left front ankle for treatment orders. LPN 1 also indicated the area should have been assessed but there was no documentation an assessment been done. Unit Manager/LPN 1 indicated a nurse saw the area on Resident 188's front left ankle when she was re-admitted from the hospital on 7/26/21 but did not document and did not notify the physician but she should have. A policy, dated 1/8/21, was provided by the Unit Manager/LPN 1 on 8/2/21 at 11:58 PM, titled "Skin Observation/Evaluation and Prevention At-A-Glance." The DON indicated it was the policy currently used by the facility. The policy indicated "1. The admitting nurse will complete and document a resident's initial skin evaluation		Licensed Nursing staff educated on the completion of Weekly Skin assessments, and Notification of Changes. Education provided on following physician orders and documentation of services provided in the clinical record. **4) How the corrective actions will be monitored:** Director of Nursing is the responsible party for this Plan of Correction. Director of Nursing/designee will Audit 3 resident records weekly to ensure weekly skin assessments have been completed and documented. Care Plans will be updated to reflect resident's status and or changes in resident condition. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)** **Date of compliance: 8-23-21.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	within 4 hours of resident admission or readmission in the Electronic Medical Record (EMR) ...3. If the admitting nurse identifies an alteration in resident's skin integrity, the findings will be documented in the EMR. The nurse will notify the physician for a treatment order and document this communication in the progress note in the EMR. 4. The admitting nurse will document a description of the identified skin alteration. Pressure ulcer/injury(s) will be documented in Wound Management. Non-pressure skin alterations will be documented in the Non-Pressure Skin Condition Record." 3.1-40(2) 3.1-40(3)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	serve food in accordance with professional standards for food service safety. Based on observation, interview and record review the facility failed to ensure proper labeling and dating of food supplies. 90 out of 91 residents consumed food prepared in the facility's kitchen. Findings include: During an observation with the Dietary Manager on 7/27/21 at 9:30 AM, 4 plastic bags of chicken thighs were observed on a cart in a plastic tub, measuring approximately 3 feet by 2 feet, in the middle of the walk-in refrigerator. The bags were sitting in a red liquid substance. The chicken thighs were not dated or labeled. A second plastic tub on the bottom shelf in the walk in refrigerator had a meat log, wrapped in white plastic, about 2 feet by 6 inches, ground beef wrapped in plastic that was about 7 inches wide, 4 inches long by 6 inches high, and kielbasa sausage that was about 1.5 foot by 8 inches wrapped in plastic wrap. None of the meat in the bin on the bottom shelf were labeled or dated. The Dietary Manager was interviewed on 7/27/21 at 9:30 AM. During the interview the Dietary Manager indicated that the chicken thighs in the plastic bags and the 3 meat items in the bin should have been labeled and dated but they had not been. A policy, was provided by resgional dietary manager, on 07/30/21 at 2:34 PM titled "Labeling and Dating" The policy indicated " ... all food items should be labeled. Labels must include, the name of time, date of preparation/receipt/removal from freezer, the use by date"	F 0812	**F 812 E Food Procurement, Store/Prepare/Serve-Sanitary** **The facility requests paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1.Immediate actions taken for those residents identified:** No resident was identified to have been affected. Identified meat products were discarded. **2.How the facility identified other residents:** Any resident residing in the facility had the potential to have been affected, however no resident was identified. **1.Measures put into place/ System changes:** Food Procurement	08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-21(i)(3)		Store/Prep/Serve-Sanitary. Education to Dietary staff on Labeling and dating of all food products. **1.How the corrective actions will be monitored:** The responsible party for this plan of correction is the Dietary manager with Executive Director oversight. Audits will be conducted daily per dietary manager/designee to determine all food is dated and labeled correctly. Executive Director will randomly, (two times weekly) review dietary audits for accuracy. Identified areas of concern will be immediately addressed. Food will be immediately discarded if found to be labeled or dated correctly. Individual education will be provided per the Executive Director regarding labeling and dating should non-compliance be identified and or disciplinary action. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance**: 8-23-2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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