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	09/20/2024

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

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00441940. Complaint IN00441940 - Deficiencies related to the allegations are cited at R0240 Survey date: September 20, 2024 Facility number: 011804 Residential Census: 112 This State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2024	R 0000	Deficiency ID R 240 410 IAC 16.2-5-4(d) Health Services Completion Date: November 27,2024 Plan of correction text: By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 15,2024. We respectfully request paper compliance for this survey resolution. Deficiency ID: R240 410 IAC 16.2-54(d) Completion Date: November 27, 2024 Plan of Correction Text: What corrective action (s) - The Wellness Director will audit all resident service plans in Memory care to ensure all resident care plans are accurate and up to date. Four charts every week until completion of all 33 charts. How the facility will identify other residents having the potential to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Lovell	Executive Director	10/03/2024

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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			be affected by the same deficient practice and what corrective action will be taken; -The facility will review care plans every 6 months/ or when occurrence arises to ensure an accurate care plan is in place. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: -After initial audit the Wellness Director will review/update each care plan every six months or if an incident occurs. The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings. Wellness Director and Executive Director will sign off on accuracy. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. -The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings. Wellness Director and Executive Director will sign off on accuracy. By what date will the systemic changes be completed-November 27, 20024	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on interview and record review the facility failed to implement interventions to prevent falls for 2 of 3 residents reviewed with falls (Resident B, Resident D). Findings Include: In an interview, on 9/20/24 at 11 AM., The Director of Nursing (DON) indicated Resident B and Resident D had recently fallen. 1. Resident B's record was reviewed on 9/20/24 at 10:24 AM. Diagnosis included dementia. A nursing note, dated 8/26/24, indicated Resident B had an unwitnessed fall in the secured courtyard. The note indicated Resident B reported complaints of pain and was sent to the hospital. A current service plan indicated assurance checks, active 3/5/2024 were completed to ensure safety while living. During an interview on 9/20/24 at 9:50 AM, the DON indicated Resident B had an unwitnessed fall on 8/25/24 in the secure courtyard. The DON indicated Resident B had complaints of pain in her leg and was sent to the hospital. The DON indicated the hospital indicated Resident B had a right femoral fracture. The DON indicated staff performed hourly checks on all residents. There were no progress notes or hourly checks	R 0240	Deficiency ID R 240 410 IAC 16.2-5-4(d) Health Services Completion Date: November 27,2024 Plan of correction text: By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 15,2024. We respectfully request paper compliance for this survey resolution. Deficiency ID: R240 410 IAC 16.2-54(d) Completion Date: November 27, 2024 Plan of Correction Text: What corrective action (s) - The Wellness Director will audit all resident service plans in Memory care to ensure all resident care plans are accurate and up to date. Four charts every week until completion of all 33	11/27/2024

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	available for review. During an interview on 9/20/24 at 11:37 AM, the DON indicated she was unable to locate the Hourly Resident Location Checklist documentation for 8/25/24 and at the time of Resident B's fall. 2. Resident D's record was reviewed on 9/20/24 at 10:35 AM. Diagnosis included dementia. A nursing note, dated 8/20/24, indicated Resident D had an unwitnessed fall at 4:37 PM with no injury. A nursing note, dated 8/25/24, indicated Resident D had an unwitnessed fall at 7:07 PM with no injury. Hourly Resident Location Checklist, dated 8/20/24, was blank for 8/20/24 from 2 PM - 9 PM. During an interview on 9/20/24 at 11:37 AM, the DON indicated she was unable to locate Hourly Resident Location Checklist documentation for 8/25/24 at the time of Resident D's fall. During an interview on 9/20/24 at 10:09 AM, Qualified Medication Aide (QMA) 2 indicated residents are checked on hourly and the information is documented on the Hourly Resident Location Checklist. A policy, last reviewed 3/2023, titled "Standard Operating Procedure," was provided by the DON on 9/20/24 at 11:59 AM. The policy did not indicate how often residents should be checked on to prevent falls. This citation relates to Complaint IN00441940.		charts. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; -The facility will review care plans every 6 months/ or when occurrence arises to ensure an accurate care plan is in place. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: -After initial audit the Wellness Director will review/update each care plan every six months or if an incident occurs. The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings. Wellness Director and Executive Director will sign off on accuracy. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. -The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings. Wellness Director and Executive Director will sign off on accuracy.	

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