PRINTED: 10/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING		COMPLETED 09/20/2024		
NAME OF PROVIDER OR SUPPLIER STORYPOINT FORT WAYNE WEST			STREET ADDRESS, CITY, STATE, ZIP COD 611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814				
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
Bldg. 00	IN00441940. Complaint IN0044 allegations are cited Survey date: Septer Facility number: 01 Residential Census This State Resident accordance with 41 Quality review con	mber 20, 2024 11804 : 112 tial Findings are cited in	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 admittin truth of accuracy of any specifindings or allegations. We rest the right to contest the finding allegations as part of proceed and submit these responses pursuant to regulatory obligations. The facility requests that the pof correction be considered of allegation of compliance effect November 15,2024. We respectfully request paper compliance for this survey resolution. Deficiency ID: R240 410 IAC 16.2-54(d) Completion Date: November 2024 Plan of Correction Text: What corrective action (s) - The Wellness Director will all resident care plans are accurated and up to date. Four charts even week until completion of all 33 charts. How the facility will identify of tresidents having the potential	fic serve as or ings ions. olan ur stive		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

State Form Event ID: HDMW11 Facility ID: 011804 If continuation sheet Page 1 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2024 FORM APPROVED OMB NO. 0938-039

A. BUILDING B. WING	00 00	COMPLETED 09/20/2024			
611 W	STREET ADDRESS, CITY, STATE, ZIP COD 611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814				
E ID FULL PREFIX ATION TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) be affected by the same defici practice and what corrective a will be taken; -The facility will review care ple every 6 months/ or when	DATE CENT CTION DATE			
	occurrence arises to ensure an accurate care plan is in place. What measures will be put into place or what systemic change the facility will make to ensure that deficient practice does no recur: -After initial audit the Wellness Director will review/update eac care plan every six months or incident occurs. The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings Wellness Director and Executi Director will sign off on accurate How the corrective action will monitored to ensure the deficing practice will not recur, i.e., who quality assurance program will put in place. -The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings. Wellness Director a Executive Director will sign of accuracy. By what date will the systemic changes be completed-Novem 27, 20024	to esses to the second of the			
	B. WING STREET A 611 W FORT V E ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP COD 611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814 FULL PREFIX TAG PREFIX TAG be affected by the same deficit practice and what corrective a will be taken; -The facility will review care ple every 6 months/ or when occurrence arises to ensure a accurate care plan is in place. What measures will be put interplace or what systemic change the facility will make to ensure that deficient practice does not recur: -After initial audit the Wellness Director will review/update ear care plan every six months or incident occurs. The Wellness Director will give completed service plans to the Executive Director weekly for review at weekly collaboration meetings Wellness Director and Execut Director will sign off on accurs. How the corrective action will monitored to ensure the deficit practice will not recur, i.e., who quality assurance program will put in placeThe Wellness Director weekly for review at weekly collaboration meetings. Wellness Director weekly for review at weekly collaboration meetings. Wellness Director weekly for review at weekly collaboration meetings. Wellness Director weekly for review at weekly collaboration meetings. Wellness Director will sign of accuracy. By what date will the systemic changes be completed-Noven			

Event ID: HDMW11 Facility ID: 011804 Page 2 of 5 State Form If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETE		(X3) DATE SURVEY COMPLETED 09/20/2024	
	PROVIDER OR SUPPLIEF		611 W	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE RD SOUTH WAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0240	410 IAC 16.2-5-4(Health Services -	. ,			
Bldg. 00	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.		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 truth of accuracy of any specifindings or allegations. We resulted the right to contest the finding allegations as part of proceed and submit these responses pursuant to regulatory obligations. The facility requests that the post of correction be considered on allegation of compliance effect November 15,2024. We respectfully request paper compliance for this survey resolution. Deficiency ID: R240 410 IAC 16.2-54(d) Completion Date: November 2224 Plan of Correction Text: What corrective action (s) - The Wellness Director will all all resident service plans in Memory care to ensure all resident care plans are accurated and up to date. Four charts exweek until completion of all 33	fic serve s or ings sons. plan ur stive

State Form Event ID: HDMW11 Facility ID: 011804 If continuation sheet Page 3 of 5

PRINTED: 10/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	A. BUILDING <u>00</u>		COMPLETED		
		B. WIN	B. WING		09/20/2024		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	I THE STATE OF THE				COUNTY LINE RD SOUTH		
STORYP	POINT FORT WAY	NE WEST	FORT WAYNE, IN 46814				
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		١,,	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	available for review.				charts.		
		•••			onaris.		
	During an interview	w on 9/20/24 at 11:37 AM, the			How the facility will identify oth	ner	
	_	e was unable to locate the		residents having the potential to be affected by the same deficient			
	Hourly Resident L						
		8/25/24 and at the time of			I - I		
	Resident B's fall.	6/23/24 and at the time of			practice and what corrective action		
	Resident D's fair.				will be taken; -The facility will review care plans		
	2 Pasident D's rec	ord was reviewed on 9/20/24 at			every 6 months/ or when	alis	
		osis included dementia.			1		
	10.55 AWI. Diagno	ssis included dementia.			occurrence arises to ensure a		
	A municipa mata da	to d. 9/20/24 indicated Davidant			accurate care plan is in place.		
	_	ted 8/20/24, indicated Resident sed fall at 4:37 PM with no			\A/I= -4		
		sed fall at 4:3 / PM with no			What measures will be put into		
	A nursing note, dated 8/25/24, indicated Resident				place or what systemic change	I .	
					the facility will make to ensure		
					that deficient practice does no	τ	
	D had an unwitnessed fall at 7:07 PM with no				recur:		
	injury.				-After initial audit the Wellness		
	II 1 D '1 / I	d' Cl. 11' (1 (1			Director will review/update ead		
	-	ocation Checklist, dated			care plan every six months or		
	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,				incident occurs. The Wellness		
					Director will give completed		
					service plans to the Executive		
					Director weekly for review at		
					weekly collaboration meetings		
					Wellness Director and Executi		
					Director will sign off on accura	acy.	
		ion Aide (QMA) 2 indicated			How the corrective action will I		
	residents are checked on hourly and the				monitored to ensure the defici-		
information is documented on the Hourly			practice will not recur, i.e., what				
Resident Location Checklist.			quality assurance program will be				
	A policy, last reviewed 3/2023, titled "Standard Operating Procedure," was provided by the DON				put in place.		
					-The Wellness Director will giv		
					completed service plans to the	;	
on 9/20/24 at 11:59 AM. The policy did not				Executive Director weekly for			
	indicate how often residents should be checked				review at weekly collaboration		
	on to prevent falls.				meetings. Wellness Director a		
					Executive Director will sign of	f on	
This citation relates to Complaint IN00441940.				accuracy.			

State Form Event ID: HDMW11 Facility ID: 011804 If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/20/2024	
NAME OF PROVIDER OR SUPPLIER STORYPOINT FORT WAYNE WEST			STREET ADDRESS, CITY, STATE, ZIP COD 611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
				By what date will the systemic changes be completed-Novem 27, 20024		

State Form Event ID: HDMW11 Facility ID: 011804 If continuation sheet Page 5 of 5