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	03/14/2023

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 the Investigation of Complaint IN00402192. Complaint IN00402192 - Federal/state deficiencies related to the allegations are cited at F744. Survey dates: March 14, 2023 Facility number: 000158 Provider number: 155255 AIM number: 100291490 Census Bed Type: SNF/NF: 78 SNF: 7 Total: 85 Census Payor Type: Medicare: 7 Medicaid: 74 Other: 4 Total: 85 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 20, 2023	F 0000		
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record	F 0744	This Plan of Correction	04/03/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FAITH MILLS	RN- Director of Nursing	04/03/2023

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	review, the facility failed to provide dementia care and services to support psychosocial well-being for 2 of 3 residents reviewed for dementia care (Resident E and Resident K). Findings include: An Indiana report, dated 2/20/23 at 1:56 p.m., indicated Resident E had a physical alteration with another resident while walking past her at the nurses station. Resident E was sent to the hospital for a psychiatric assessment. The female resident (Resident K) involved was observed with discoloration below her left eye. Resident E returned to the facility the same day as the altercation and there had been no further altercations. Both residents resided on the locked memory care unit. On 3/14/23 at 10:43 A.M., Resident E's record was reviewed. Diagnoses included dementia with psychotic disturbance, major depressive disorder, generalized anxiety disorder, insomnia, and delusional disorder. A quarterly MDS (Minimum Data Set) assessment, dated 2/13/23, indicated a BIMS (Brief Interview Mental Status) score of 9-moderately impaired cognition. He had mood indicators of feeling down, depressed, hopeless; 12-14 days feeling tired with little energy; and 7-11 days having trouble concentrating. He had no behaviors or delusions. He was on an antipsychotic medication as well as a antidepressant and antianxiety medication. Care plans indicated the following: -Initiated 1/5/21, the resident had intermittent periods of confusion, demonstrated poor safety		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. Deficiency ID: F 744 SS=D Date of Completion: April 3, 2023 1. It is the intent of the facility to ensure all residents that have the diagnosis of Dementia receive the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. The facility sent the resident to the hospital in Fort Wayne. They sent the resident back to Celebrate Senior Living, however, the resident had to be sent to another Psych hospital out of town due to continuing behaviors and the facility was unable to give appropriate treatment at Celebrate Senior	

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	awareness, and had impulsive tendencies. Interventions included to remind him to slow down and think things through prior to proceeding with a task. -Initiated 2/16/22 and revised 2/22/23, the resident had combative behaviors towards other such as hitting, pushing, kicking, verbal aggression and refusing medications. He had the following behaviors: 2/16/22: resident to resident altercation; 7/14/22: resident pushed another resident down; 8/4/22: kicked at another resident; 12/4/22: smacked another resident on the back; and 2/19/23: combative with another resident. The goal was he would not harm himself or others. Interventions, with dates initiated, were: 2/16/22-analyze key times, places, circumstances, triggers, and what de-escalates behavior and document; 2/16/22-assess and anticipate resident's need for food, thirst, toileting, comfort, body position, and pain; 2/16/22-document and report to doctor or nurse practitioner (NP) of danger to self or others; 12/4/22-document observed behavior and attempted interventions in behavior log; 2/16/22-provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out a staff member when agitated; 2/16/22-psychiatric/psychogeriatric consult as needed; 7/14/22-reinforce unacceptance of combative behaviors towards others; and 2/16/22-when agitated, intervene before escalates, guide away from the source of distress, engage calmly in conversation and if aggressive, staff should walk away and approach later. -Initiated 6/20/22 and revised 2/15/23, the resident uses psychotropic medications related to anxiety,		Living. No other residents were affected by this deficiency. 2. An audit was performed on all 31 residents that reside on the Dementia unit to assure that each resident is appropriate for the dementia unit according to their BIMS and current cognition (#1 attachment). 3. Licensed nursing staff, SS. Director for the unit and SS for the rest of the building has been in-serviced as of March 30, 2023 and ongoing until all appropriate staff has been in-serviced on accurate assessments for placement on the unit and care plans that reflect the resident's cognition, psychosocial well-being and accurate BIM scores. (#2 attachment). 4. Audits will be performed by the Social Service Director/Designee, at least 5X's a week for one month and with every new admit, then 2X's a week for one month and with every new admit. Random monitoring will be completed X 4 months and with every new admit, to assure residents are properly placed on the unit and their psychosocial well-being is met. (see attachment#3). Social Service Director/Designee will address in the monthly QAPI/QA meetings for 6 months. It is the intent of the facility to assure 100% compliance with regulations.	

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	delusions, and dementia. He has had recent tremors secondary to possible side effects. His antipsychotic and antianxiety medications were discontinued. Interventions, all dated 6/20/22, were: administer medications as ordered and monitor for side effects; consult with pharmacy and doctor to consider dose reductions when appropriate; monitor/record occurrence for target behavior symptoms and document; and monitor/record/report side effects of medications. On 3/14/23 at 10:35 A.M., Resident E was observed seated in a rocking chair near the bird cage on the memory care unit. Activities were occurring at a table a short distance from his chair but his gaze was focused on a western on a TV located across the lounge. He was well groomed, rocked gently back and forth in the rocking chair, and had a flat but undistressed affect. Several female residents sat quietly dozing in their wheelchairs around another table that was near the TV the resident was looking at. At the table where a card activity was occurring, sat Resident K whom Resident E had an altercation with on 2/18/22. Resident K spoke loudly and shared her opinions with residents seated at the table. Resident E hadn't appeared to notice or acknowledge her. -During a continuous observation from 1:31 P.M. to 1:55 P.M., Resident E was observed seated in the same rocking chair as the morning. Residents, including Resident K, sat at the same table and were playing another game. 2 female resident's were wandering around the lounge area. Resident E was rocking quickly and with force in the rocking chair. He would look around often and was observed moving his lips as if talking to himself as there were no residents near him. His mouth was in a frown, eyebrows furrowed and he continued rocking hard and fast. His face			

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	indicated he was troubled. One of the wandering resident's walked past his chair and he stopped rocking until she passed and then resummed rocking. Progress notes indicated the following: -12/4/22 at 10: 16 p.m., indicated Resident E had walked past Resident K and smacked the back of her head and neck. He indicated he hadn't meant any harm, apologized and indicated he had thought she was another male resident. -12/14/22 at 1:26 p.m., a behavior note indicated the resident had been wandering around the unit, shutting off lights. Staff tried to redirect him but he would yell at staff when they turned the lights back on. He was agitated and aggressive. -12/15/23 at 9:57 a.m., a behavior note indicated the Social Services Director (SSD) followed up with the resident and his behaviors the day before. He was calm and in no distress. Activities were to work on getting some interactive activities going to help stimulate the residents. The note indicated the resident was "cycling and his restlessness and agitation would increase during this time". -12/27/22 at 5:10 p.m., a behavior note indicated the the resident was calling staff names and using profanity. He wanted to contact the police to file a report against staff for being liars. He called the nurse a liar and a "man" and told her to leave his room. The psychiatric NP was notified and ordered an antipsychotic medication be given at that time. A psychiatric NP note, dated 1/3/23 at 7:07 a.m., indicated the resident had been seen due to			

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	agitation, refusal of care, and paranoia which was distressing to him. The resident was visited while he sat in the lounge area. He was observed speaking to himself. His mood was guarded, no anxiety but was irritable and agitated at times. The plan was for him to remain on his antianxiety medication 3 times per day and continue with an antipsychotic medication to be given 1 time per day before bed. He remained on medication to help him sleep at night. A nurse progress note, dated 2/10/23 at 9:17 a.m., indicated the resident was observed with his body violently jerking. The resident indicated he felt like his body was being shocked. The NP was in the facility and came to exam him. New orders were given for a 1 time dose of oral steroid and discontinue his antianxiety and antipsychotic medications. He was to be closely monitored. A behavior note, dated 2/18/23 at 8:46 a.m., indicated the resident was sent to the hospital due to increased behaviors and physically hitting another resident. Resident K's progress notes indicated on 2/18/23 at 9:49 a.m., Resident K was observed sitting by the nurses station in her wheelchair. Resident E walked up behind her and tried to move her wheelchair. Resident K said "no". Resident E grabbed the resident's hair and hit her in the head 2 times. The residents were seperated, neurological checks were started on Resident K and she was given an ice pack for her head. She was administered Tylenol for complaints of a headache. On 3/14/23 at 2:00 P.M., the Memory Care Unit Director-LPN 3 (Licensed Practical Nurse) was interviewed. She indicated when Resident E was			

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	observed with tremors on 2/10/23 at 9:17 a.m., he was placed on 15 minute checks for 3 days to monitor for any further tremors which had not been observed. She indicated there had been no further altercations between Resident E and Resident K since 2/18/23. Resident E usually sat in his room and had no further behaviors. On 3/14/23 at 2:53 P.M., the SSD was interviewed. She indicated Resident E had a history of cycling (a pattern of distinct episodes) with behaviors but was not having any at this time. The care plan hadn't indicated when he cycled, what behaviors were associated with cycling, or interventions to prevent altercations between residents when cycling. When questioned, she indicated the resident had been put on an anti-psychotic medication in December 2022 due to his behaviors towards staff, not residents. There were no specific behaviors being monitored or behavioral interventions put into place following the altercation between Resident E and Resident F on 12/4/22 or 2/18/23. There was no analysis completed of key times, places, circumstances, triggers, and what de-escalates his behaviors. On 3/14/23 at 3:45 P.M., currrent copies of facility policies for Psychotropic Medication Management and Behavioral Health Management were provided which indicated resident's behavioral health needs were assessed, monitored and evaluated on an ongoing basis; pharmacologic interventions were used when clinically indicated or when non-pharmacologic interventions were ineffective; and those on psychotropic medications would have behaviors monitored, number of episodes, and interventions and outcomes documented. This Federal tag relates to Complaint IN00402192.			

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