STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155828	A. BUILDING 00 B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

(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 the Investigation of Complaints IN00395994 and IN00397132. Complaint IN00395994 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00397132 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 28 and 29, 2022 Facility number: 012931 Provider number: 155828 AIM number: 201278730 Census Bed Type: SNF/NF: 17 SNF: 30 Total: 47 Census Payor Type: Medicare: 5 Medicaid: 17 Other: 25 Total: 47 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 3, 2023	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Souder	Executive Director	01/06/2023

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
	155828	A. BUILDING 00 B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

(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
	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to implement care plan interventions to prevent falls for 1 of 5 residents reviewed. (Resident T). Findings include: On 12/28/22 at 12:09 P.M., Resident T's record was reviewed. Diagnoses included hemiplegia and hemiparesis affecting the right non-dominant side. MDS (Minimum Data Set) assessments, dated 9/8/22 and 12/6/22, indicated a BIMS (Brief Interview Mental Status) score of 9-moderately impaired cognition. The resident required extensive assistance from 2 staff members for transfers. Care plans indicated the following: -Resident T had an ADL self-care deficit due to right sided hemiplegia. Interventions included: (initiated on 9/17/21) Hoyer-mechanical lift as needed; provide extensive to total assistance from 1-2 staff members and use of hemiwalker for all transfers. -The resident was at high risk for falls due to weakness and right hemiplegia. Interventions included: place a sign as a reminder to use the hemiwalker for transfers (created 12/28/22). Progress notes indicated:	F 0689	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The Facility respectfully requests paper compliance for this citation. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing Services and the MDS Coordinator completed a safety and fall risk assessments completed for Resident T. Appropriate revisions were made to the care plans to reflect all current safety interventions. The revised assessments and care plans were reviewed with staff involved in the care of each resident. 2. Identification of other residents having the potential to be affected was accomplished by: The nursing management team	01/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155828	A. BUILDING 00 B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

(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
	-11/23/22 at 6:53 p.m., the resident had a fall witnessed by the nurse, CNA (Certified Nurse Aid) and resident spouse. He was being assisted from his wheelchair to his recliner, was very unstable, fell back against the chair with his bottom at the edge of the seat, and slid down to the floor. -11/24/22 at 10:28 a.m., a fall follow up was completed. He had a skin tear present from his fall, on the right lateral wrist. -12/1/22 at 3:53 p.m., per the CNA, they had attempted to transfer the resident from his wheelchair to his recliner after lunch. The resident was unable to complete the transfer and was lowered to the floor. He had no obvious injuries. -12/6/22 at 4:45 p.m., the CNA reported the resident was on the floor in front of his recliner. He had no obvious injuries. The CNA indicated she had attempted to transfer him from his recliner to the wheelchair when his leg gave out and she lowered him to the floor. On 12/29/22 at 9:28 A.M., CNA 5 was interviewed. During the interview, she indicated at times, Resident B could be transferred with 1 staff member. She would try to assist him to stand but if he was weak or unable to, she would set him back down and get another staff member to help her. She indicated he was tall which made it more difficult to transfer him. There was no documentation in Resident B's record to indicate care plan interventions were put into place to prevent further falls from occurring. The resident's MDS assessments indicated he required extensive assistance from 2 staff		reviewed the MDS Assessments for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All Licensed Nursing staff will be inserviced on the new facility policy for *Accidents and Supervision (attachment A)*. All resident falls/accidents will be reviewed daily by the IDT to ensure appropriate implementation of safety interventions including updating the plan of care (*attachment B*) . **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and updated plan of care is complete. The Director of Nursing Services (DNS), or designee, will complete random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155828	A. BUILDING 00 B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

(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
	members for transfers. Falls on 11/23, 12/1, and 12/6/22 occurred when the resident was transferred by only 1 staff member. A current facility policy, titled "Fall Program", provided by the Administrator on 12/28/22 at 10:30 A.M., stated the following: "Purpose: 1. To identify residents who are at risk for falling. 2. Identification of precipitating events leading up to falls that do occur. 3. Identify pattern in falls. 4. Implement interventions to prevent or reduce the incidence of further falls...Procedure...3. Any resident that sustains a fall will be discussed at the the fall IDT committee meeting. Discussion to include all factors noted on the incident report, Fall Scene Investigation, Fall Huddle, and Root Cause Analysis...." This Federal tag relates to Complaint IN00395994. 3.1-45(a)		monthly for 5 months. *(Attachment C) (Attachment D)* Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Should 100% compliance not be achieved, findings will be submitted to Risk Management/Quality Assurance Committee for further interventions to achieve total compliance.	