

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

PRINTED: 02/13/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 01/18/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP COD 4730 E STATE BLVD 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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00423902. Complaint IN00423902 : Deficiencies related to the allegations are cited at R0118. Survey date: January 18, 2024 Facility number: 003273 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 19, 2024			R 0000	The following is the Plan of Correction for Brookdale Fort Wayne regarding the Statement of Deficiencies dated January 18, 2024. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.		
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees						

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

TITLE

(X6) DATE

Tonya Bollin

Health & Wellness Director

02/12/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>in this category are either a certified nurse aide or a home health aide.</p> <p>Based on interview and record review the facility failed to ensure assistance with activities of daily living was provided by qualified staff for 1 of 3 residents reviewed (Resident B).</p> <p>Findings include:</p> <p>During a record review on 1/18/24 at 11:28 AM, a document titled Incident Investigation ...dated 12/11/23 was reviewed. The record indicated Certified Nurse Aide (CNA) 2 reported to Health and Wellness Director (HWD) 4 she had heard Cook 3 had performed personal care for Resident Bon 12/11/23 at 2:00 PM. The record indicated the resident was not interviewable.</p> <p>The document indicated Cook 3 was interviewed by the Administrator on 12/11/23 at 3:00 PM. In the interview, Cook 3 indicated he had helped Resident B put her shirt on. The Administrator informed Cook 3 he was suspended, he was instructed to leave the building and await contact from the facility.</p> <p>The document indicated CNA 5 was interviewed on 12/12/23 at 1:45 PM by the HWD. CNA 5 indicated Cook 3 told her he had helped Resident B get dressed the previous day.</p> <p>Resident B's record was reviewed on 1/18/24 at 11:13 AM. Diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbance.</p> <p>A Job Summary form for the job title of cook, dated 1/10, did not include responsibilities of direct resident care. The form contained the</p>			R 0118	<p>R118:</p> <p>Resident B had no negative affects related to the non-certified associate changing her shirt. The associate was terminated. Residents have the potential to be affected. The associate was terminated. Associates were re-educated by the Health and Wellness Director on 02/6/2024 about following their job description and that no unlicensed associates can provide any ADL care to the residents. New hires will sign their job description during orientation. The Executive Director and/or designee will review all new hire paperwork to verify the associate signed their job description during orientation. Any identified issues will be addressed in the daily stand up meeting Monday thru Friday.</p>		02/09/2024

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	<p>signature of Cook 3 and was dated 4/10/23..</p> <p>In an interview on 1/18/24 at 12:05 PM, the Administrator indicated Cook 3 had told her he assisted Residnet B with putting on her shirt. Only nurses, certified nurse aides, or home health aides should provide anything beyond limited assistance with activities of daily living for residents. She indicated staff were made aware of their expected duties and the parameters of their role in the facility in the orientation process. She indicated employees acknowledged their understanding of their responsibilities by signing their job description. She indicated the facility did not have a specific policy directing unqualified employees to not provide care to residents.</p> <p>This citation is related to complaint IN00423902.</p>						