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

FORM APPROVED
OMB NO. 0938-039

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	10/19/2023

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 Complaints IN00418709 and IN00418732. Complaint IN00418709 - State deficiencies related to the allegations are cited at R0240. Complaint IN00418732- No deficiences related to the allegations are cited. Survey date: October 19, 2023. Facility number: 001184 Residential Census: 101 This State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 19, 2023	R 0000	By submitting the enclosed materials, we are not admitting the truth or 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 effect November 13, 2023. We respectfully request paper compliance for this survey resolution.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview the facility failed to ensure residents received shower assistance based on their preferences for 3 of 3 residents reviewed (Resident B, Resident I, Resident J). Findings include: A shower schedule was provided by the Director of Nursing (DON) on 10/19/23 at 4:36 PM. The schedule indicated the following:	R 0240	All resident are to be offered showers at least two times per week. All residents requiring assistance with showering will have shower sheets reflecting residents preferences at least twice per week. -What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice and what	11/13/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emiley Jewett	LPN, DON	11/03/2023

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.

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	Resident B preferred showers on 2nd shift on Sunday, Monday, Tuesday, Wednesday, Thursday, Friday and Saturday each week. Resident I preferred showers on 2nd shift on Tuesday and Friday each week. Resident J preferred showers on 2nd shift on Wednesday and Saturday each week. Shower sheets, dated 8/2/23 - 10/19/23, were provided by the DON on 10/19/23 at 4 PM. The shower sheets indicated: 1. Resident B received a shower on 8/19/23, 8/21/23, 8/22/23, 8/23/23, 8/24/23, 8/25/23, 8/26/23, 8/27/23, 8/28/23, 8/30/23, 8/31/23, 9/1/23, 9/2/23, 9/3/23, 9/8/23, 9/10/23, 9/30/23, and 10/19/23. 2. Resident I received a shower on 8/11/23, 8/17/23, 9/29/23, 10/6/23, 10/10/23, and 10/13/23. The shower sheets also indicated Resident I refused a shower on: 9/22/23, 10/3/23 and 10/17/23. 3. Resident J received a shower on 8/5/23, 8/12/23 and 8/16/23. In an interview on 10/19/23 at 4:36 PM, the DON indicated she did not have any additional documentation regarding Resident B, Resident I or Resident J's showers. The DON indicated the facility did not have specific policy regarding bathing. The DON indicated residents received showers at least 2x a week or based on the resident/families preferences. The DON also indicated the shower schedule reflected the resident/families' preferences. In an interview on 10/19/23 at 1:31 PM, Certified Nurse Aide (CNA) 3 indicated residents were offered showers at least 2x a week or based on the		corrective action will be taken; The Wellness Team Supervisor (WTS) will audit all residents on shower services to ensure the residents are assigned at least two showers per week based on their preferences. The shower sheets will be completed and turned into the WTS to track compliance per the residents requests. - 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 realizes that residents could have had the potential to be affected by the alleged deficient practice. - What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur; A WTS has been promoted from within with a proven track record for her through and exceptional work history at the facility and given administrative tasks to ensure compliance to our goals of meeting our residents expectations for quality care/compliance. The WTS will audit 100% residents requiring shower services in Memory Care Unit #1 (MC1) one week, the following week Memory Care Unit	

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	resident/families preferences. CNA 3 indicated the staff followed a shower schedule. CNA 3 also indicated showers were not offered or completed by staff on 2nd shift. In an interview on 10/19/23 at 2:39 PM, CNA 4 indicated residents received showers based on the shower schedule. CNA 4 indicated if a shower was offered and/or completed a shower sheet was completed. In an interview on 10/19/23 at 3 PM, CNA 2 indicated at times staff refused to offer residents showers or residents were not offered showers on 2nd shift. This citation relates to Complaint IN00418709.		#2 (MC2) and the following week in Assisted Living (AL). Each week The WTS will report her weekly finding to Director of Nursing (DON). This cycle will repeat itself until the Unit obtains 100% compliance for offering and documenting the showers for four straight weeks. If a Unit obtains 100% compliance for four straight weeks then it will be dropped from the weekly audit to a monthly audit. If a Unit obtains 100% on a monthly audit for three months then it will only be audited Quarterly. The Audits will continue for at least six months. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The DON/designee will report the findings of the shower monitor to the QAPI - By what date the systemic changes will be completed 13-Nov-23	