

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER STORYPOINT FORT WAYNE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD SOUTH, FORT WAYNE, , 46814			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 470265 and 470754. Intake 470265 - No deficiencies related to the allegations are cited. Intake 470754 - State deficiencies related to the allegations are cited at R0029, R0240, and R0349. Survey dates: July 29 and 30, 2026 Facility number: 011804 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 31, 2026	R 0000			
R 0029	Residents' Rights - Deficiency	R 0029	Deficiency ID: R 029 410 IAC	09/11/2026	

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410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure residents were treated with respect and dignity during communications for 1 of 3 residents reviewed (Resident D). Findings include: A report, dated 7/9/26, indicated a staff member had been overheard yelling at Resident D in the dining room. Resident D was removed from the area and the staff member sent home pending investigation of the incident. On 7/29/26 at 2:50 P.M., Resident D was observed sitting in a chair in the living room area of the secured memory care unit. She had a scowl on her face as she fiddled with items in the basket of her walker. She engaged in conversation and spoke about her preference for bright colors like ones she was wearing on her boots and jacket. She indicated she was doing as best as could but had no specific concerns. Resident D's record was reviewed on 7/29/26 at 3:34	16.2-5-1.2(d) Resident's Rights-Deficiency Completion Date: September 11, 2026 Plan of correction text: By submitting the enclosed materials, we are not admitting the truth of 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 effective September 11, 2026. We respectfully request paper compliance for this survey resolution. Deficiency ID: R 029 410 IAC 16.2-5-1.2(d) Resident's Rights Completion Date: September 11, 2026 Plan of Correction Text: Executive director and Wellness Director will ensure all staff in the community has completed the assigned Resident Rights Training Modules in Relias What corrective action (s) - The executive director and wellness will assign two modules on resident rights to all
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P.M. She had a diagnosis of Alzheimer's dementia and resided on the secured Memory Care Unit (MCU). A Service Plan, last reviewed on 5/4/26, indicated Resident D was independent with most of her activities of daily living but required assistance and encouragement with bathing. She had no other behaviors requiring staff interventions. Staff were to administer her medications and treatments, including her eye drops, given daily. On 7/29/26 at 3:02 P.M., Qualified Medication Aid (QMA) 4 was interviewed. She was always scheduled to work 2nd shift on the MCU and knew Resident D well. She indicated the resident could be very persistent about her eye drops and expected them at the time they were to be given. On 7/29/26 at 3:20 P.M., the Memory Care Unit (MCU) Director was interviewed. She indicated, on 7/7/26, she and 2 other staff members had been in her office on the unit when she heard yelling coming from the dining room. She heard Qualified Medication Aid (QMA) 2 yelling she didn't have Resident D's eye drops. She went to the dining room and observed QMA 2 yelling at	staff in the community to be completed -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; Staff will have yearly modules to be completed on resident rights. Staff will have Face to face resident rights training at orientation and quarterly. -What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: Executive director and wellness director and designee will ensure that all new hires have had training on resident rights before staff begin working on the floor. -How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.	
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Resident D from across the dining room while the resident was trying to get into the medication cart. QMA 2 indicated the resident wanted her eye drops but she didn't have them. The Director assisted Resident D from the room and consoled her as she was upset and crying. The MCU Director indicated for the past month, QMA 2 had been asking to be removed from working on the unit due to personal stress and burnout but had not been moved. She hadn't known why the QMA was not moved when she expressed burnout. The Director of Nursing (DON) spoke with QMA 2 who indicated the resident kept demanding she be given her eye drops and wouldn't move away from the medication cart. The MCU Director indicated QMA 2 was sent home pending investigation of the incident.

On 7/30/26 at 10:45 A.M., the Assistant Director of Nursing (ADON) was interviewed about QMA 2 continuing to work on the MCU despite having asked to be removed. The ADON indicated, QMA 2 had been under some extreme personal stress the past few months and had asked to be moved to another hall which was done. However, there were several times when QMA 2 would change the schedule and put

The executive Director and wellness director will review Relias completion weekly for 4 weeks and then every 2 weeks for 2 months and then quarterly . Face to face training will be reviewed quarterly

By what date will the systemic changes be completed:

September 11th 2026

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herself on the MCU.

On 7/30/26 at 1:26 P.M., the Administrator was interviewed. She indicated QMA 2 had been scheduled on another hall but 2-3 times, had changed the schedule to work over on the MCU. She indicated having met with QMA 2 on 7/9/26 to discuss the incident. QMA 2 indicated there had been much going on during the time of the incident. She had been across the dining room from the resident who kept trying to get into the cart. She was frustrated and indicated she should've asked to take a break and should not have yelled at the resident. The Administrator indicated QMA 2 should not have yelled at Resident D.

The Administrator indicated on 7/30/26 at 10:05 A.M., the facility had no specific written Resident Rights form but followed the State regulations as written and posted on the wall for residents. She indicated it was a resident's right and company expectation that all residents be treated with respect and dignity during communication and care.

This Citation relates to Intake 470754.

R 0240	Health Services - Deficiency	R 0240	Deficiency ID: R 240 410 IAC 16.2-5-4(d) Health Services	09/11/2026
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410 IAC 16.2-5-4(d)

(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.

Based on interview and record review, the facility failed to ensure care was provided per physician orders and service plans for 1 of 3 residents reviewed (Resident B).

Findings include:

On 7/29/26 at 10:40 A.M., Resident B's daughter indicated she was very upset about wound care provided to her mother who had several wounds on her legs. She indicated treatments to the wounds were not being done timely or according to physician orders. The wounds had worsened and she was going to have to take the resident to the wound clinic.

On 7/29/26 at 12:35 P.M., Resident B was observed in her room. She used a walker and was observed with an abnormal gait. She indicated she only had one leg because the other one no longer worked. She wore long pants with sandals and when she sat down, her right pant leg came up and a dressing was observed beginning at the ankle. There was some clear fluid on the dressing. When asked, she

Deficiency

Completion Date: September 11, 2026

Plan of correction text:

By submitting the enclosed materials, we are not admitting the truth of 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 effective September 11, 2026. We respectfully request paper compliance for this survey resolution.

Deficiency ID: R 240 410 IAC 16.2-5-4(d) Health Services

Completion Date: September 11, 2026

Plan of Correction Text:

Wellness director or designee will ensure all personal care and activities of daily living are provided based upon personal preference.

What corrective action (s)

- The Wellness Director or designee will follow up daily to ensure care plans are followed. The Wellness Director or

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denied pain. A record review, completed on 7/29/26 at 3:00 P.M., indicated Resident B's diagnoses included heart failure, venous insufficiency, and atherosclerotic heart disease requiring her to be on hospice services. A Service Plan, last reviewed on 5/5/26, indicated she had treatments requiring assistance from staff. The resident had an order for a daily dressing change. Hospice was to complete the daily dressing change on Monday, Wednesday, and Fridays. The Service Plan hadn't indicated who was responsible for dressing changes on Tuesday, Thursday, Saturday, and Sundays. A current physician order, dated 6/2/26, was for Manuka honey wound gel paste-to be applied to the wound site, covered with an ABD dressing, wrapped with kerlix and secured with tape every day and as needed for soilage. The order hadn't indicated the wound site(s) where the treatment was to be applied to. Hospice notes indicated: -6/1/26: Wound care was provided to the resident.	designee will review MARS and have weekly meeting with Executive Director to discuss all findings going forward. -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 Wellness Director or designee will review all resident care plans to identify if any opportunities with care and update care plans as needed. Care plans will be reviewed semi annually or upon any substantial change in resident or facility's request -What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: Wellness Director or designee will ensure all care plans are updated within 3 business days to reflect any updates with care. -How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place. The Wellness Director and Executive Director will continuously monitor care plans	
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Dressings to both lower legs were removed and areas cleansed. The wound on the right lower leg was pink in color without excessive drainage and current wound treatment appeared to be effective. The wound on the left lower leg had improved however, a new treatment was going to be started. Treatment to the right lower leg would continue as ordered and the leg wrapped from the knee to ankle to help reduce swelling. There was no order written for a wound treatment to the left lower leg. The physician order on 6/2/26 for Manuka honey wound gel paste hadn't indicated if it was for the right or left leg. On 6/8/26, Hospice notes indicated wound care was provided to the resident and wounds measured. Resident B had a venous stasis ulcer on the left lower outer calf and venous stasis ulcer on the right shin. The right wound had some drainage but no signs of infection. The left leg wound had deteriorated however, the treatment to the left leg would not be changed at the time. The note indicated dressings were changed according to the care plan. On 6/12/26, Hospice nites		every 6 months or upon significant changes and ensure updates during weekly meetings going forward. Weekly service plans will be reviewed every week for weeks then monthly going forward to ensure 100% complainance By what date will the systemic changes be completed: September 11, 2026	
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indicated Resident B was out of the facility and the wound treatment was not completed.

On 6/13/26, Hospice notes indicated Resident B was seen for wound treatment. Wound care was provided per orders to the right lower extremity. The wound to the left lower extremity was assessed for worsening and possible change in treatment to be the same as treatment to the right leg. The left lower leg wound appeared to be deteriorating and treatment was going to be changed to be the same as treatment on the right leg however, the resident declined to have it changed.

Wound treatments to the right and left leg wounds continued with different orders for each leg. There was no order written for treatment to the left leg. The order continued as written on 6/2/26. The order hadn't indicated which leg wounds were to be treated with the honey gel paste daily nor was there a different wound treatment order for the left lower leg.

On 6/15/26 and 6/19/26, Hospice notes indicated wound care to right and left leg wounds was provided per orders.

On 6/22/26, Hospice notes indicated wound measurements

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and assessments were completed. The right lower extremity wound was reported by Resident B to be leaking more and she requested wounds be dressed daily. The right leg appeared at baseline without signs of infection. The left leg wound appeared to be declining with increasing size. Initial dressings were malodorous but once wounds were cleansed, there was no further odor.

On 6/26/26, Hospice notes indicated wound care to right and left leg wounds was completed. The Hospice nurse went over with the resident when hospice nurses would do her dressing changes and when facility staff would do the treatments.

On 6/29/26, Hospice notes indicated wound care was provided as ordered.

On 7/2/26 (Thursday), Hospice notes indicated wound care was provided as ordered. The right lower leg had increased swelling but no signs of infection.

On 7/6, 7/10, 7/13, 7/17, 7/20, and 7/24/26, Hospice notes indicated wound care provided as ordered. Some non-verbal discomfort from the dressing change was observed on 7/20/26.

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	On 7/27/26, hospice notes indicated wound care provided as ordered. Both extremity wounds had increased clear colored drainage but no signs of infection. A skin/wound note, dated 6/22/26 at 12:43 p.m., indicated new wound orders were received from hospice staff to discontinue current wound treatment orders. On Tuesday, Wednesday, Thursday, Saturday, and Sundays, facility staff were to remove kerlix dressing and ABD, leave hydrofoam blue in place. Cleanse surrounding tissues, cover with ABD pad, wrap with kerlix and secure with tape. Hospice staff would complete wound care and cleansing of the wound bed on Monday and Fridays. There was no order written to indicate wound treatment changes were made by hospice on 6/22/26. There were no changes made to the service plan to indicate hospice and facility staff coordination had changed, which days hospice would perform wound care, and days staff would be responsible for wound care. A Medication Administration Record (MAR), dated June 2026, indicated by nurse initials, wound treatment was completed			
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	daily with administration of Manuka honey wound gel paste to un-named wound site(s), covered with ABD pad, wrapped with kerlix and secured with tape everyday with exceptions on 6/8, 6/19, 6/22, 6/26, and 6/29/26 when treatments were completed by hospice staff. There were no other physician ordered treatments documented. An MAR, dated July 2026, indicated by nurse initials, wound treatment was completed daily with administration of Manuka honey wound gel paste to un-named wound site(s), covered with ABD pad, wrapped with kerlix and secured with tape everyday. There were no other physician ordered treatments documented. On 7/30/26 at 1:05 P.M., during an interview with the Assistant Director of Nursing (ADON), she indicated the resident's wound sites should have been documented on the service plan. Treatment orders were to indicate the location of wounds and where to apply the treatment. The Administrator and ADON were interviewed on 7/30/26 at 2:00 P.M. The ADON indicated she had not been aware of the changes in the resident's treatment of her leg wounds.			
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	There was a discrepancy between physician orders for wound treatment and hospice wound documentation. She indicated physician ordered treatments were to be placed on the MAR and initialed off each day to indicate completion of the treatment. Hospice staff and nursing staff were to coordinate care including wound treatment schedules. She indicated all services provided to the resident were to be on the service plan and followed as written and per physician orders. This Citation relates to Intake 470754.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure physician orders were	R 0349	Deficiency ID: R 349 410 IAC 16.2-8.1(a)(1-4) Clinical Records -Non Compliance Completion Date: September 11, 2026 Plan of correction text: By submitting the enclosed materials, we are not admitting the truth of 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	09/11/2026

transcribed, accurately documented on medication administration records, and initialed as completed for 1 of 3 residents reviewed for complete and accurate records (Resident B).

Findings include:

A record review, completed on 7/29/26 at 3:00 P.M., indicated Resident B's diagnoses included heart failure, venous insufficiency, and atherosclerotic heart disease, the reason she was on hospice services.

A Service Plan, last reviewed on 5/5/26, indicated Resident B had treatments requiring assistance from staff. The resident had orders for a wound daily dressing change. Hospice was to complete the daily dressing change on Monday, Wednesday, and Fridays.

A current physician order, dated 6/2/26, was for Manuka honey wound gel paste-to be applied to the wound site, covered with an ABD dressing, wrapped with kerlix and secured with tape every day and as needed for soilage.

The order hadn't indicated the wound site(s) where the treatment was to be applied to.

A skin/wound note, dated

effective September 11, 2026. We respectfully request paper compliance for this survey resolution.

Deficiency ID: R 349 410 IAC
16.2-8.1(a)(1-4) Clinical
Records

Completion Date: September
11, 2026

Plan of Correction Text:

Wellness director or designee will ensure physician orders are transcribed accurately

What corrective action (s)

- The Wellness Director or designee will follow up daily to ensure all orders are entered correctly into Point Click Care. The Wellness Director or designee will review orders and have weekly meeting with Executive Director to discuss all findings going forward.

-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 Wellness Director or designee will review all resident's new orders to identify if any opportunities with care and update care plans as needed.

6/22/26 at 12:43 p.m., indicated new wound orders were received from hospice staff to discontinue current wound treatment orders. On Tuesday, Wednesday, Thursday, Saturday, and Sundays, facility staff were to remove the kerlix dressing and ABD, leave hydrofoam blue in place. Cleanse surrounding tissues and cover with ABD pad, wrap with kerlix and secure with tape. Hospice staff would complete wound care and cleansing of the wound bed on Monday and Fridays.

There was no order written to indicate wound treatment changes made by hospice on 6/22/26. There were no changes made to the service plan indicating hospice and facility staff coordination had changed, the days hospice would perform wound care, and days staff would be responsible for wound care.

A Medication Administration Record (MAR), dated June 2026, indicated by nurse initials, wound treatment was completed daily with administration of Manuka honey wound gel paste to un-named wound site(s), covered with ABD pad, wrapped with kerlix and secured with tape everyday with exceptions on 6/8, 6/19, 6/22, 6/26, and 6/29/26 when treatments were

-What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:

Wellness Director or designee will ensure all orders are transcribed into Point Click Care within 1 business day to reflect any updates with care.

-How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.

The Wellness Director or Designee will transcribe ensure orders are transcribed accurately every business day for 4 weeks and then on a weekly basis for 6 months. The Wellness Director and Executive Director will continuously discuss and collaborate to ensure any updates are completed and any concerns are addressed during weekly meetings going forward

By what date will the systemic changes be completed:

September 11, 2026

completed by hospice staff.

There was no physician order written for changes in wound treatments on 6/22/26 as documented in the skin/wound note.

An MAR, dated July 2026, indicated a physician order for daily wound treatment with Manuka honey wound gel paste to un-named wound site(s), covered with ABD pad, wrapped with kerlix and secured with tape everyday. The MAR had blank spaces where nurses were to initial having administered the treatment on 7/2, 7/4, 7/5, 7/18, 7/19, 7/23, and 7/28/26.

There was no physician order written for changes in wound treatments on 6/22/26 as documented in the skin/wound note.

On 7/30/26 at 1:05 P.M., during an interview with the Assistant Director of Nursing (ADON), she indicated the resident's wound sites should have been documented on the service plan. There was a discrepancy between physician orders for wound treatment and hospice wound documentation. She indicated treatment orders were to indicate the location of wounds, where to apply the treatment, placed on the MAR and initialed off each day to

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FORM APPROVED

OMB NO. 0938-0391

indicate completion of the treatment. The change in wound treatment documented on 6/22/26, should have had a physician order written, documented on the MAR, and initialed by nurses after administering the treatment.

This Citation relates to Intake 470754.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATUREEmiley Jewett

TITLEDirector of Nursing

(X6) DATE08/18/2026