STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT FORT WAYNE WEST	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 Complaints IN00463615, IN00463743 and IN00464114. Complaint IN00463615 - No deficiencies related to the allegations are cited. Complaint IN00463743 - No deficiencies related to the allegations are cited. Complaint IN00464114 - Deficiencies related to the allegations are cited at R0214 and R0241. Survey date: August 22 and 25, 2025 Facility number: 011804 Residential Census: 103 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed August 26, 2025			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure care plans and service assessments were followed and updated for 2 of 5 residents reviewed (Resident B, Resident C). Findings include: 1. Resident B's record was reviewed on 8/22/25 at 11:22 AM. Diagnoses included dyspnea and transient cerebral ischemic attack. An order, dated 6/13/2025, indicated Resident B received an Ipratropium-Albuterol inhaled Solution 0.5/2.5 3 MG/3 ML via nebulizer three times a day for shortness of breath. The treatment was unsupervised. A Medication Administration	R 0214	Deficiency ID: R 214 410 IAC 16.2-5-2(a) Evaluation-Deficiency Completion Date: October 31,2025 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 October 31,2025. We respectfully request paper compliance for this survey resolution. Deficiency ID: R 214 410 IAC 16.2-5-2(a) Evaluation	10/31/2025

	Record (MAR) dated July 1, 2025 - August 25, 2025, indicated Resident B self-administered 27 doses of the respiratory treatment. The current care plan, dated 6/13/25, indicated Resident B needed assistance three times a day with respiratory treatments. A current service assessment, dated 6/13/25, indicated Resident B received respiratory treatment and needed assistance with set up and administration. During an interview, on 8/22/25 at 11:28 AM, Resident B's daughter indicated an order for respiratory treatments indicated to administer three times a day. The facility indicated they administered the respiratory treatment two times a day during the week due to the lack of scheduled nurses. Resident B's daughter indicated Resident B could not self-administer the breathing treatment and needed assistance from the nurses. 2. Resident C's record was reviewed on 8/22/25 at 12 PM. Diagnoses included neuropathy and hypertension. An order, dated 8/7/25, indicated Resident C received an Ipratropium-Albuterol inhaled Solution 0.5-2.5 3 MG/3 ML via nebulizer three times a day for shortness of breath for seven		Completion Date: October 31,2025 **Plan of Correction Text**: Wellness director will ensure all care plans are updated and followed by all staff **What corrective action (s)** - The Wellness Director will follow up daily to ensure care plans are followed. The Wellness Director 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 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	

	days for an upper respiratory infection. The care plan indicated Resident C needed assistance with medication administration. The care plan did not indicate Resident C received respiratory treatments. A current service assessment, dated 5/4/25, indicated Resident C did not receive respiratory treatments but needed assistance with medication administration. A current care plan, last revised 5/4/2025, did not indicate Resident C received respiratory treatments. The care plan indicated Resident C needed assistance with medication administration. During an interview, on 8/22/25 at 12:42 PM, the Director of Nursing (DON) indicated neither Resident B nor Resident C were able to self-administer respiratory treatments. The DON indicated the order, care plan and service assessment reflected the assistance required for the resident's respiratory treatments. A policy, dated 2018, titled Standard Operating Procedures, was provided by the DON on 8/25/25 at 10 AM. The policy indicated care plans are updated immediately with any change in care or condition. The		-**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 will ensure all care plans are updated 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 and Executive Director will continuously monitor care plans and ensure updates during weekly meetings going forward **By what date will the systemic changes be completed**: October 31,2025	

	policy also indicated service plans addressed medication management the residents required and were to be followed. This finding relates to Intake IN00464114. Based on interview and record review, the facility failed to ensure care plans and service assessments were followed and updated for 2 of 5 residents reviewed (Resident B, Resident C). Findings include: 1. Resident B's record was reviewed on 8/22/25 at 11:22 AM. Diagnoses included dyspnea and transient cerebral ischemic attack. An order, dated 6/13/2025, indicated Resident B received an Ipratropium-Albuterol inhaled Solution 0.5/2.5 3 MG/3 ML via nebulizer three times a day for shortness of breath. The treatment was unsupervised. A Medication Administration Record (MAR) dated July 1, 2025 - August 25, 2025, indicated Resident B self-administered 27 doses of the respiratory treatment.			

The current care plan, dated 6/13/25, indicated Resident B needed assistance three times a day with respiratory treatments.

A current service assessment, dated 6/13/25, indicated Resident B received respiratory treatment and needed assistance with set up and administration.

During an interview, on 8/22/25 at 11:28 AM, Resident B's daughter indicated an order for respiratory treatments indicated to administer three times a day. The facility indicated they administered the respiratory treatment two times a day during the week due to the lack of scheduled nurses. Resident B's daughter indicated Resident B could not self-administer the breathing treatment and needed assistance from the nurses.

2. Resident C's record was reviewed on 8/22/25 at 12 PM. Diagnoses included neuropathy and hypertension.

An order, dated 8/7/25, indicated Resident C received an Ipratropium-Albuterol inhaled Solution 0.5-2.5 3 MG/3 ML via nebulizer three times a day for shortness of breath for seven days for an upper respiratory infection.

The care plan indicated Resident C needed assistance with medication administration.

	The care plan did not indicate Resident C received respiratory treatments. A current service assessment, dated 5/4/25, indicated Resident C did not receive respiratory treatments but needed assistance with medication administration. A current care plan, last revised 5/4/2025, did not indicate Resident C received respiratory treatments. The care plan indicated Resident C needed assistance with medication administration. During an interview, on 8/22/25 at 12:42 PM, the Director of Nursing (DON) indicated neither Resident B nor Resident C were able to self-administer respiratory treatments. The DON indicated the order, care plan and service assessment reflected the assistance required for the resident's respiratory treatments. A policy, dated 2018, titled Standard Operating Procedures, was provided by the DON on 8/25/25 at 10 AM. The policy indicated care plans are updated immediately with any change in care or condition. The policy also indicated service plans addressed medication management the residents required and were to be followed.			

	This finding relates to Intake IN00464114.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review the facility failed to ensure residents received medications as ordered for 2 of 5 residents reviewed (Resident B, Resident C). Findings include: 1. Resident B's record was reviewed on 8/22/25 at 11:22 AM. Diagnoses included dyspnea and transient cerebral ischemic attack. An order, dated 6/13/2025, indicated Resident B received an Ipratropium-Albuterol inhaled Solution 0.5-2.5 (3) MG/3 ML via nebulizer three times a day for shortness of breath. A Medication Administration	R 0241	Deficiency ID: R 241 410 IAC 16.2-5-4(e)(1) Health Services Completion Date: October 31,2025 Deficiency ID: R 241 410 IAC 16.2-5-4(e)(1) Health Services Completion Date: October 31,2025 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 October 31,2025. We respectfully request paper compliance for this survey resolution. What	10/31/2025

	Record (MAR) dated July 1, 2025 - August 25, 2025, indicated Resident B missed 44 doses of the respiratory treatment. During an interview on 8/22/25 at 11:28 AM, Resident B's daughter indicated the facility indicated there were no nurses on the weekends to administer Resident B's respiratory treatments. Resident B's daughter indicated the order was to administer three times a day. The facility indicated they administered the respiratory treatment two times a day during the week. Resident B's daughter indicated Resident B could not self-administer the breathing treatment and needed assistance from the nurses. 2. Resident C's record was reviewed on 8/22/25 at 12 PM. Diagnoses included neuropathy and hypertension. An order dated 8/7/25-8/14/25, indicated Resident C received an Ipratropium-Albuterol inhaled Solution 0.5-2.5 (3) MG/3 ML via nebulizer three times a day for shortness of breath for seven days for an upper respiratory infection. A MAR, dated August 2025, indicated Resident C missed 7 doses of the respiratory treatments. During an interview on 8/22/25		corrective action (s) - The Wellness Director will ensure all medications are received by all residents as ordered by physician. -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 will review MARS to ensure medication is being administered timely -What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: The Wellness Director will meet with the Executive Director weekly about MARS completion and have ongoing check ins to ensure incident does happen again. -How	

	at 10:46 AM, Qualified Medication Aide (QMA) 2 indicated the nurse administered respiratory treatments to residents as ordered. QMA 2 indicated the administration of respiratory treatment was out of scope of the QMA. QMA 2 indicated there were no nurses scheduled on the weekends and the residents did not receive respiratory treatments on the weekends. During an interview on 8/22/25 at 12:42 PM, the Director of Nursing (DON) indicated nurses were the only staff allowed to administer respiratory treatments. The DON indicated no nurses were scheduled on the weekends. The DON indicated when the family or resident was unable to perform the respiratory treatment, the resident did not receive the respiratory treatment on the weekends. The DON indicated Resident B nor Resident C were able to self-administer their respiratory treatments. During an interview on 8/25/25 at 10:25 AM, the DON indicated the facility did not have a policy. The DON indicated residents received medications as ordered by the physician. This finding relates to Intake IN00464114.		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 MARS completion rate weekly at weekly meetings By what date will the systemic changes be completed: October 31,2025	

Based on interview and record review the facility failed to ensure residents received medications as ordered for 2 of 5 residents reviewed (Resident B, Resident C).

Findings include:

1. Resident B's record was reviewed on 8/22/25 at 11:22 AM. Diagnoses included dyspnea and transient cerebral ischemic attack.

An order, dated 6/13/2025, indicated Resident B received an Ipratropium-Albuterol inhaled Solution 0.5-2.5 (3) MG/3 ML via nebulizer three times a day for shortness of breath.

A Medication Administration Record (MAR) dated July 1, 2025 - August 25, 2025, indicated Resident B missed 44 doses of the respiratory treatment.

During an interview on 8/22/25 at 11:28 AM, Resident B's daughter indicated the facility indicated there were no nurses on the weekends to administer Resident B's respiratory treatments. Resident B's daughter indicated the order was to administer three times a day. The facility indicated they administered the respiratory treatment two times a day during the week. Resident B's daughter indicated Resident B could not self-administer the

breathing treatment and needed assistance from the nurses.

2. Resident C's record was reviewed on 8/22/25 at 12 PM. Diagnoses included neuropathy and hypertension.

An order dated 8/7/25-8/14/25, indicated Resident C received an Ipratropium-Albuterol inhaled Solution 0.5-2.5 (3) MG/3 ML via nebulizer three times a day for shortness of breath for seven days for an upper respiratory infection.

A MAR, dated August 2025, indicated Resident C missed 7 doses of the respiratory treatments.

During an interview on 8/22/25 at 10:46 AM, Qualified Medication Aide (QMA) 2 indicated the nurse administered respiratory treatments to residents as ordered. QMA 2 indicated the administration of respiratory treatment was out of scope of the QMA. QMA 2 indicated there were no nurses scheduled on the weekends and the residents did not receive respiratory treatments on the weekends.

During an interview on 8/22/25 at 12:42 PM, the Director of Nursing (DON) indicated nurses were the only staff allowed to administer respiratory treatments. The DON indicated

	no nurses were scheduled on the weekends. The DON indicated when the family or resident was unable to perform the respiratory treatment, the resident did not receive the respiratory treatment on the weekends. The DON indicated Resident B nor Resident C were able to self-administer their respiratory treatments. During an interview on 8/25/25 at 10:25 AM, the DON indicated the facility did not have a policy. The DON indicated residents received medications as ordered by the physician. This finding relates to Intake IN00464114.			

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 SIGNATURELaura Lovell	TITLEExecutive Director	(X6) DATE09/17/2025