STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417508. Complaint IN00417508 - Federal/state deficiencies related to the allegations are cited at F744. Survey dates: September 26 and 27, 2023 Facility number: 000214 Provider number: 155321 AIM number: 100267240 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicaid: 28 Other: 11 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 4, 2023.	F 0000		
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review, the facility failed to develop and implement individualized interventions for	F 0744	F 744 It is the policy of the facility to ensure a resident who displays or	10/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindy S. Lawson	Administrator	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	dementia care to support psychosocial well-being and address aggressive behaviors for 2 of 3 residents reviewed (Resident B and Resident C). Findings include: 1. On 9/26/23 at 11:49 A.M., Resident B's family member was interviewed. They indicated several concerns with the resident's care and condition including multiple falls, bruising, lack of activities, multiple medication changes, swelling in legs, and an alleged physical altercation with another resident who had been aggressive towards her. They believed the facility thought Resident B had been the aggressor, but the other resident had been the one to strike her. The family member indicated they had offered suggestions to the facility on how to care for the resident, including information about her favorite activities and likes/dislikes, but believed the facility hadn't tried to incorporate any of these suggestions into her plan of care. When family visited, the resident was alleged to usually be sleepy and not engaged in activities, which they believed contributed to her depression and behaviors. Resident B had a passion for playing solitaire and had kept score of how many games she'd won, which was over a thousand games. She enjoyed crocheting, cooking, prepping for meals, and house work although she hated folding clothes/towels. The family member indicated she could only do these activities for short periods of time due to her dementia, but they had been things that had been important to her and part of her daily life. On 9/26/23 at 1:34 P.M., Resident B's clinical record was reviewed. Diagnoses included dementia with behavioral disturbances, anxiety disorder, depression, delusions, and sleep disorder.		is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being and address aggressive behaviors. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident B & C person centered care plans updated to reflect current alternative/adaptive activities per resident preference. On 10/16/2023 care plans were updated by the Activity Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents with diagnosis of dementia in facility have the potential to be affected by the alleged deficient practice. Activity Director or designee will complete facility wide audit to verify residents with dementia diagnosis are provided alternate or adaptive activities, as needed, per resident preference. This will be completed by 10/20/2023. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Administrator educated Activity Director and activity department	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	Her clinical record indicated she had been sent to the hospital on 7/24/23 for a psychiatric evaluation, but was found to have COVID-19 pneumonia. She remained hospitalized with pneumonia until 8/1/23, when she returned to the facility. On 8/4/23, she was transported to a psychiatric hospital for a medication washout (psychotropic medications are stopped and re-evaluated for need or change in medications). She returned to the facility on 8/15/23 with physician orders for Mellaril (antipsychotic) 10 mg (milligrams) by mouth 4 times per day and Celexa (anti-depressant) 10 mg by mouth 1 time per day for behavior management. A quarterly MDS (Minimum Data Set) assessment, dated 6/7/23, indicated the resident had severely impaired cognition, understood others and was able to be understood when communicating, and had disorganized thinking which fluctuated in severity. She had several mood indicators which included feeling tired or having little energy; feeling bad about herself; and trouble concentrating 7-11 days. She had verbal behaviors directed toward others 4-6 days but had no rejection of care or wandering. Her behaviors were managed with antipsychotic, anti-anxiety and anti-depressant medications. Current care plans indicated the following: Initiated 1/13/23: the resident had impaired cognition. Interventions, dated 1/13/23 included: allow resident time to respond, anticipate her needs when able, encourage activities, and offer support and reassurance. Initiated 12/22/22: elopement. Interventions, dated 12/22/22, included: provide resident with		on facility policy to ensure a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being in regards to alternate or adaptive activities, and individualized interventions for dementia care as needed, per resident preference on 10/16/23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. “Alternate/Adaptive Activities audit tool of individualized interventions to be implemented for dementia residents along with MDS care plan audits to ensure activity and staff are appropriately doing assigned interventions. Audit tool will be completed 5 days a week x 4 weeks,3 days a week, x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	diversional task when exit seeking such as snack or drink. Initiated 1/3/23 and revised 8/28/23: the resident was at risk for behavioral disturbances related to dementia with behaviors, psychosis and mood disorder; currently receiving anti-depressant and anti-anxiety medications. The goal was for the resident to have no episodes of behaviors. Interventions, dated 1/3/23, included: 1 to 1 as needed, anti-psychotic medications per orders, monitor effectiveness of medications, observe for behaviors, let resident know what you are doing during care, approach her calmly and quietly, offer activity of choice, and psychiatric services per orders. Initiated 2/9/23: the resident had a diagnosis of insomnia. The goal was for the resident to be restful at night. Interventions, dated 2/9/23, were encourage her to avoid caffeinated foods prior to bedtime, encourage her to do more activities, medications as ordered; observe for effectiveness, and notify physician as needed. An Activity Admission Evaluation form, dated 9/15/23 at 12:39 p.m., indicated the assessment was for re-admission to the facility, collected from the staff and was as follows: The resident had no religion type and had not practiced. She was oriented to person only. Poor short term/long term memory with short attentions span. She could read but not write. Her current recreational interests were art/crafts projects; spiritual programs/religious services; gardening; fitness/exercise; listening to music; social parties/group activities; talking/conversing; and enjoyed folding blankets and clothes.		needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of compliance 10/20/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	There was no information collected from the family regarding her activities preferences. The evaluation was summarized as the resident having a hard time participating in group activities due to anxiety and behaviors. She enjoyed independent activities such as folding laundry, but was unable to stay focused on a single task for extended periods of time. There was no care plan developed for activities or dementia programming. On 9/26/23 from 10:30 A.M. to 10:55 A.M., during a tour of the memory care unit (MCU), 5 residents were observed seated on the couch and in wheelchairs of the living room, watching a movie on the TV. Resident B was observed seated in a chair, which sat in back of the living room area. She had purple bruising beneath her left eye. CNA 5 (Certified Nurse Aide) was observed to assist the resident in putting on her jacket. CNA 5 moved away and the resident was observed to slowly and unsteadily rise up from the chair. She stood and fidgeted with her jacket and kept repeating she didn't know what was going on. She wore tennis shoes and had both legs visible beneath her pant legs, which showed ace wraps around her calves. She started to take off her jacket, let it fall to the ground, and started to remove her shirt. CNA 5 intervened and was overheard to tell the resident "we are not gonna do this today" and assisted the resident to put her arm back in the sleeve of her shirt and put back on her jacket. She slowly wandered around the living room area, into the hall towards the dining room, and back into the living room. The dining room/activity room was located across from the living room area and was dark with no lights on. Resident B had a frown on her face, furrowed eyebrows, grimacing at times, and tearfulness. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	kept repeating she hadn't known where she was or what was going on and was very difficult to re-direct from her obvious anxiety. CNA 5 was interviewed and indicated they just let Resident B alone because she was non-redirectable. On 9/26/23 at 12:14 P.M., Resident B was observed in the dining room, seated at a table with other female residents and drinking lemonade. The dining room was quiet with no music or interactions occurring between residents or staff. On 9/26/23 from 3:35 P.M. to 3:55 P.M., the MCU was observed. There were 5 residents in the living room area playing balloon toss with an activities staff member. Resident B was observed slowly walking around the dining room. She went to the sink and turned on the water and rinsed her fingers, fiddled with the door to the refrigerator and walked slowly around the tables. She appeared sleepy, with her eyes half open and mouth drooping, and supported herself against the wall between the dining and living room. She indicated she was exhausted. She had worked all day helping her mother by doing all the dusting and laundry and was ready to rest. On 9/27/23 at 9:30 A.M., the MCU was observed. There were 3 residents sitting in the living room, all with their eyes closed and appearing to sleep. An activity staff member was in the corner of the dining room with 2 male residents and was painting their fingernails. Resident B was observed walking around the dining room and hall area. She appeared tired and confused. A review of progress notes indicated the following: On 8/15/23 at 7:18 p.m., the resident was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	readmitted to the facility. She was agitated and indicated she hadn't understood what was happening, needed to get out of here, and needed her purse. She was exit seeking and tried to push open the door to the unit. The behavior had occurred since 4 p.m. and attempts to redirect her with snacks, attention and TV were ineffective. On 8/16/23 at 2:25 a.m., the resident awoke at 2:00 a.m. and reported anxiety and being scared. She asked the nurse to prayer with her, which was effective and the resident returned to bed. At 11:15 a.m., the resident was seen by the psychiatric NP (Nurse Practitioner) and new orders were given for Xanax (anti-anxiety) 0.5 mg by mouth 3 times per day as needed x 14 days for anxiety. At 4:12 p.m., the resident was given Xanax 0.5 mg for anxiety/distress and exit seeking, which was ineffective. The note lacked non-pharmacological interventions attempted. On 8/17/23 at 5:23 a.m., RN 8 indicated the resident woke up briefly around 2 a.m., but was pleasant and allowed the nurse to complete her assessment. She had no reports of the resident having anxiety. At 5:35 a.m., the QMA (Qualified Medication Aide) administered Xanax 0.5 mg by mouth to the resident. There was no documentation to indicate symptoms or behaviors the resident was having. At 11:30 a.m., the resident had been observed walking the hallway when she reached for something on a room door, lost her balance, stumbled and fell onto her knees. She had no apparent injury. On 8/21/23 at 1:53 a.m. and 3:15 a.m., the resident had wandering/exit seeking behaviors, entered other resident rooms and took their personal belongings, wanted to call her mom and dad and indicated she needed to get out of here.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	Redirection was ineffective. At 9:50 p.m., the resident continued with anxiety and was combative with staff and used profanity. Xanax 0.5 mg was given and ineffective. The note lacked non-pharmacological interventions attempted. On 8/25/23, at unknown time, a behavioral health note, written by the therapist, indicated the resident had been seen for services related to specific behavioral and mood symptoms noted by staff including sundowning, anxiety, depression, pacing, exit seeking and delusions. During the visit, the resident was anxious, searching for her mother, and difficult to redirect. On 8/25/23 at 6:01 p.m., the resident was sitting in the dining room, sobbing and asking "where are they". 1:1, redirection, and snacks were all ineffective. On 8/26/23 at 4:57 a.m. and 6:14 p.m., the resident paced the floor, was exit seeking, crying and made negative comments towards herself. On 9/4/23 at 3:15 a.m., the resident had broken sleep all night. She had been up and down from her bed and recliner and her behaviors were disruptive to her roommate. Redirection, multiple staff approach, food/drink, toileting, 1:1 and change of environment provided but ineffective. On 9/5/23 at 9:34 p.m., per shift report, the resident had been given Xanax at 3 p.m. due to tearfulness, exit-seeking, and hitting doors and tables. This shift, she continued to pace. She was encouraged to elevate her legs and rest but would only do so for very short periods of time (5-10 minutes). She paced the hallway and asked repeated unintelligible questions with expressions of worry about getting things done. 1:1 and calming talk			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	with reassurance was effective for only brief periods of time. An Incident Note, dated 9/6/23 at 2:02 a.m., indicated Resident B had been smacked by Resident C in the face, and knocked off her glasses. The QMA separated them and notified the nurse. Resident B was crying and reported severe pain. She had a raised purple area to the corner of her left outer eye that measured 2 cm (centimeters) by 2.5 cm. An all over skin check was done and a large dark purple bruise was observed on her right breast that measured 9 cm by 11 cm and a smaller purple bruise measuring 2.5 cm by 3.5 cm to her outer right breast. Resident B was given some pain medication and offered ice for her left eye. Both were started on 15 minute safety checks. An IDT (Interdisciplinary Team) note indicated there had been an altercation between the resident and a peer. Resident B resided on the MCU with advancing dementia and periods of anxiety, sundowning, exit seeking and aggression towards others. She had a small hematoma/bruising to her outer left eye with no vision changes. She hadn't appeared to remember the incident and couldn't provide any details. She had poor sleeping patterns and had not slept much during the night in the last 72 hours. She paced the unit, often going/in and out of other rooms, banging on doors/tables and yelling throughout the hall. 15 minute safety and neurological checks would be done for the next 72 hours. The note hadn't indicated the resident had extensive bruising on her breast and there was no documentation about cause of the bruise. No new non-pharmacological interventions were addressed. A psych NP note, dated 9/6/23, indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	resident's mood was fragile and she was verbally and physically aggressive. She was tearful with frequent mood swings and was difficult to redirect. She would be started on Xanax 1 mg tablet by mouth, 2 times per day and continue with Xanax 0.5 mg 3 times per day as needed. On 9/7/23 at 12:19 p.m., the resident was redirected numerous times throughout the day to take a rest from walking which she had been doing with her eyes closed. She was offered "alternative" activities. She sat down and ate her lunch with the other residents. On 9/8/23 at 2:37 p.m., the resident had been attempting to sit back into her wheelchair, but missed and landed on the carpet in front of her wheelchair in the lounge. New orders were received to discontinue the Xanax 1 mg 2 times per day but continue with the as needed Xanax 0.5 mg every 8 hours. On 9/9/23 at 5:31 a.m., Resident B had been able to go to sleep until 1:00 a.m. and woke up at 4:00 a.m. Upon awakening, she was uncooperative with care, paced the hallways, banged on the walls and begged to go to God and heaven and was upset staff couldn't take her there. She was toileted, given food and drink and given Xanax. On 9/10/23 at 3:19 p.m., the resident had a small bluish bruise to her left buttock most likely from fall on 9/8/23. She complained of discomfort and started to strip her clothes off saying "I probably have a lot of bruises, do you want to see"? On 9/13/23 at 3:21 p.m., a care plan meeting was held with the resident's daughter. Staff shared that the resident had been doing well with behaviors when they kept her busy doing house related			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	activities such as folding laundry and helping with fake money. They requested the family bring in a purse for her to carry the fake money in. A behavior health note, dated 9/15/23 by the therapist, indicated the resident's mood was anxious/worried. Staff reported that the resident finally slept last night after 3 days with very little sleep. Her anxiety medications were decreased due to falling recently. There was no evidence of significant emotional distress but continued with much confusion. Therapist tried different music for her to listen to and she indicated she hadn't liked any of them. She relaxed when she was played sounds of the ocean-she actually had fallen asleep but had awoken startled and wanted to know if it was time to leave. The resident may benefit from some type of white noise in her room to sleep and may benefit from a weighted blanket. These interventions were not included in the resident's care plans. An Incident Note, dated 9/19/23 at 5:59 a.m., indicated the resident was observed to fall from the couch onto her bottom. She was assisted back into her chair. She reported pain in her chest where she had an old bruise. Bruising also remained to her buttocks, left eye and other scattered old bruises. On 9/21/23 at 5:21 a.m., the resident had slept from 9 p.m. until 3:30 a.m. and then got up and began pacing the halls, banging on the walls, and yelling out for help. She was crying and pushing the medication and treatment carts around. She was provided a snack, which helped. At 10:32 a.m., a weekly progress note indicated as needed Xanax had been effective for outbursts of yelling and self hurt (punching the wall with her fist). She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	participated in a coloring activity this a.m. On 9/23/23 at 5:27 a.m., the resident was anxious, pacing, and pounding on the walls. She had been given Xanax at 12:09 a.m. and had slept in the recliner chair until 4 a.m. When she got up, she began pulling on the couch, pounding on the doors, pulling on the railing, yelling for help, urinated in a wheelchair and trash can after being toileted. At 5:00 p.m., she had increased anxiety and abrupt behaviors; constant pacing; stated she wanted to die and hadn't wanted to be here. Xanax was administered per orders. The note lacked non-pharmacological interventions attempted. On 9/24/23 at 5:11 a.m., resident had been up all night exit seeking, banging on doors, screaming and going into other resident rooms. Redirection was unsuccessful. On 9/26/23 at 2:10 a.m., resident was screaming for help and disrobed 3 times. She declined to go to bed until 2 a.m. At 4:00 a.m., the QMA observed the resident fall from the recliner onto the floor. She had a small skin tear to her left lateral pinky finger which was cleansed and bandaged. At 1:18 p.m., new orders were gotten for extra strength Tylenol and Ibuprofen for pain. The note lacked non-pharmacological interventions attempted. On 9/26/23 at 2:08 P.M., the Director of Nursing (DON) was interviewed. She indicated staff had tried several interventions that were unsuccessful in managing her behaviors. The resident had previous inpatient psychiatric visits, prior to admission to the facility for dementia related behaviors. She would be prescribed medications and they would only work for short periods of time and then her behaviors would escalate. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	extensive bruising to the resident's breast was reported to her, and she was told the resident would injure herself by running into the walls, furniture, and medication carts and would hit the walls with her fist. It had been assumed the extensive bruising and continued observation of new bruises was due to these episodes in addition to the falls. There was all new administrative staff, including the activities department. There was not a designated activities person for the MCU, or structured dementia programming at this time, but LPN 3 (Licensed Practical Nurse) was the newly designated MCU Director and would be working on activities for the unit. On 9/26/23 at 3:36 P.M., LPN 9 was interviewed. She indicated Resident B's behaviors were resistant to interventions and she would become angry and hit the wall with her hands but hadn't seen her purposefully run into objects to hurt herself. At times, the resident would swing her arms out at staff if she was upset and didn't want to be cared for at the time. On 9/26/23 at 3:38 P.M., CNA 12 was interviewed. She indicated activity staff would come down and do an activity with residents, usually once a day. Staff would play movies or music before supper. When Resident B had behaviors and was anxious, she would be comforted by staff sitting right next to her and touching her leg to leg however, when staff had to get up and move away, she would get anxious again. She had witnessed the resident hitting the wall before in frustration and anger. 2. On 9/26/23 at 3:45 P.M., Resident C was observed lying in her room in bed. Her eyes were open and she smiled. She was holding a stuffed dog. She had not been observed during the day to be up in her wheelchair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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

On 9/27/23 at 12:33 P.M., Resident C's record was reviewed. Diagnoses included Alzheimer's disease with late onset, dementia with behavioral disturbances, depression and delusional disorder.

A quarterly MDS assessment, dated 8/17/23, indicated the resident had severely impaired cognition. She had no mood indicators or behaviors.

Current care plans included the following:

Revised on 9/14/23: the resident had mood issues exhibited by delusions such as looking for children and people in "her house"; entering others rooms to look for them, yelling at staff to get out and becoming agitated and aggressive at times. Goals included: Her verbal aggression and anger towards other would not result in injury to self or others. Interventions included: provide support with skills to de-escalate, cope, and manage stress, provide pet therapy or animal visitors, take outside for sunshine and fresh air, listen to her concerns and follow up on these promptly, provide support and encouragement, and psych services to follow as needed.

Initiated on 11/11/19: Resident had insomnia and was prescribed routine medication for sleep. Interventions included: assess for pain.

Initiated on 10/22/19: the resident had depression due to losses and decline in health. Her depressive symptoms were crying, tearfulness, and irritability. Interventions included: provide support and encouragement as needed.

A psych NP note, dated 8/30/23, indicated the resident was seen for having episodes of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	tearfulness and expressions of pain from recent hip fracture. Her pain medication had been increased, which helped, and she did well when her pain was under control. She was described as doing better after being transferred back to memory care. She did become teary in the evening hours with increased dementia symptoms. She was observed on this day resting in bed and pleasantly confused. Staff were to monitor and document any new or worsening behaviors. She was to continue on her anti-depressant and medication for her sleep disorder. A review of progress notes indicated the following: On 9/2/23 at 5:17 a.m., the resident had intermittent crying and anxiety during the evening. She was consoled by talking and back rub. She was assisted to bed and asleep at 9:30 p.m. These successful interventions were not added to the care plan. On 9/3/23 at 4:30 a.m., the resident slept for about 1-2 hours tonight and had 2 episodes of crying. The note lacked non-pharmacological interventions attempted. On 9/6/23 at 1:54 a.m., the QMA reported that Resident C smacked another resident in the face, knocking off her glasses. The residents were immediately separated. The resident declined vitals and assessment. The resident was started on 15 minute safety checks. An IDT note, dated 9/6/23 at 9:58 a.m., indicated the resident had a physical altercation with another resident. She had a history of aggression towards others and had fluctuating moods at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	times. She was often up during the night hours and would nap during the day. Investigation indicated the resident was attempting to convince Resident B to sit down and when Resident B yelled, she struck her with an open hand, in her face and knocked her glasses off. The residents were separated and the resident was redirected and left alone. Staff had reported an increase in frequency of aggressive behaviors which had become worse in the evening/night hours. The note lacked non-pharmacological interventions to be added to the plan of care. A psych NP note, dated 9/6/23, indicated the resident had behaviors that were aggressive and occurred mostly at nighttime with tearfulness. Her antipsychotic medication was re-ordered after having been discontinued in April 2023. An Incident Note, dated 9/8/23 at 4:54 a.m., indicated the resident continued on 15 minute safety checks. She had denied having any pain, but was observed to be limping. She was not aggressive but had anxiety, depressive symptoms, restlessness and insomnia. She declined to lay in bed until 1:20 a.m. but was up again at 1:45 a.m., crying, indicating she needed to go home. She was assisted "home", toileted and back to bed at 1:50 a.m. but was back up 10 minutes later crying and unable to indicate what was wrong. She laid back down and fell asleep after 3 a.m. The note lacked non-pharmacological interventions attempted. On 9/10/23 at 3:00 a.m., the resident had increased agitation, resistance to care and physical aggression toward staff and other residents on shift. She finally calmed after multiple interventions, 1:1, calm approach by multiple different staff, change of environment, food and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	drink. At 9:23 p.m., the resident had been tearful for the past hour and was now showing aggressive behavior towards staff and another resident. She was cursing and swinging and hit the nurse in the jaw and CNA in the arm. The note lacked non-pharmacological interventions attempted. On 9/11/23 at 10:15 p.m., resident was combative with staff after dinner. She punched staff, threw objects and attempted to be combative with other residents. She was able to be calmed down some but continued with behaviors. On 9/12/23 at 9:19 p.m., reported that resident had slept all day. She was tearful during the evening, but unable to say what was wrong. A psych NP note, dated 9/20/23, indicated the residents family had expressed concern about the resident being restarted on her antipsychotic and was requesting it be discontinued. Hospice services were meeting with the family on this day due to the resident significant change in condition and ongoing decline. Antipsychotic medication was to be weaned and discontinued in 7 days. On 9/21/23 at 1:27 a.m., the resident was admitted to hospice on 9/20/23 for Alzheimer's dementia. The QMA reported the resident had been angry and was swinging an object at staff because she hadn't wanted care. The note lacked non-pharmacological interventions attempted. On 9/22/23 at 1:41 a.m., per shift change, the resident was combative, resistant to care, aggressive and punched "someone",which was reported to management. At bedtime, she had weakness and was resistant to help up from the couch into her wheelchair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	On 9/27/23 at 9:25 A.M., CNA 8 was interviewed. She indicated Resident C was very sweet and used to care for herself but now was no longer eating, required assistance and could be combative with care. The previous week, there had been an altercation with another resident- not Resident B- but hadn't thought there were anymore. On 9/27/23 at 10:09 A.M., the DON was interviewed. She indicated Resident C had been upset with another resident and had yelled at her. She attempted to smack the other resident, but the QMA intervened before contact was made. The residents were separated from one another. The facility tried to staff a QMA and a CNA on night shift on the MCU, but they were having difficulty with staffing. She acknowledged there had been only a QMA working the night of 9/6/23, when the altercation occurred between Resident B and Resident C, making it difficult for 1 staff member to provide care and supervision to residents with behaviors. On 9/27/23 at 12:15 P.M., the DON provided a current copy of the facility's policy, titled "A Dedicated Dementia Care Unit Philosophy" which indicated the following: "...We believe that the quality of life for our resident's are enriched when their days are filled with meaningful and enjoyable structured activity. We believe that this activity serves as a powerful coping mechanism in times of fear and stress...The memory care unit provides " a specific and screened population, a safe and secure environment that is not overstimulating, free from unnecessary medications, provides activities structured specifically for functionally limited residents, offers rich sensory stimulation, residents are treated with dignity and respect, are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 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
	provided with patience, dignity and acceptance and resident behaviors are interpreted and not challenged...." This Federal tag relates to Complaint IN00417508. 3.1-37(a)			