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	04/19/2024

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 Complaints IN00431619, IN00432307, and IN00432367 Complaint IN00431619 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00432307 - Federal/state deficiencies related to the allegations are cited at F699. Complaint IN00432367 - No deficiencies related to the allegations are cited. Survey dates: April 18 and 19, 2024 Facility number: 000214 Provider number: 155321 AIM number: 100267240 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 3 Medicaid: 34 Other: 10 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 23, 2024	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure identification, assessment and follow up for acute changes in resident's condition following 2 falls for 1 resident reviewed (Resident B). Findings include: On 4/18/24 at 10:38 A.M., Resident B's record was reviewed. Diagnoses included congestive heart failure, dementia, diabetes, and repeated falls. The resident had recently been hospitalized following a fall resulting in fractured ribs and large hemothorax (condition where blood collects in the space between the lungs and rib cage usually as a result of injury/trauma to the chest). A hospital note, dated 3/31/24 at 11:51 a.m. by a hospital trauma doctor, indicated the resident had been sent to the hospital from the nursing home due to shortness of breath and concern for acute medical problem. Initially, there had been no report of history/mechanism of trauma however, trauma staff were concerned when the resident was found to have fractured ribs and large hemothorax which required insertion of a chest tube to drain the blood. The resident had a small area of bruising over one cheek, scattered abrasions, and significant bruising to his right lateral chest wall, right flank, and right knee. The nursing home was contacted who indicated the resident had fallen 2 times in the past 7-10 days.	F 0689	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is May 10th, 2024. Facility is respectfully requesting paper compliance for all deficiencies in this POC. F 689 It is the intent of this facility to ensure the facility identifies, assesses, and follows up for acute changes in condition following falls. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident B had new assessments completed upon readmission. Fall Risk assessment completed with new baseline established. IDT updated. Care Plan reviewed and updated. DON completed the	05/10/2024

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	A quarterly MDS (Minimum Data Set) assessment, dated 3/8/24, indicated Resident B had a BIMS (Brief Interview Mental Status) score of 14-no cognitive impairment. He had no mood or behavior issues; no functional impairments; and used a walker and wheelchair for mobility. He required supervision with toileting hygiene, upper body dressing, and personal hygiene. He was independent with bed mobility, sit to stand transfers, toilet transfers, and chair to chair transfers. He was able to walk short distances with his walker and supervision. A care plan for falls, revised on 4/6/2020, indicated the resident was at risk for falls due to dementia, forgetfulness, impaired vision, unsteady gait, impaired balance and history of falls. The goal, revised on 8/14/23, was to reduce his fall risk factors to avoid significant injury related to falls. Interventions and dates initiated were: 8/19/2019-call light in reach, monitor for changes in gait, and notify doctor of change in condition. 9/16/2019-provide reacher/grabber to have by him when doing puzzles/crafts. 3/25/24-analyze previous falls to determine pattern, do no leave in bathroom unattended, encourage him to use handrails and assistive devices properly, evaluate/assess psychotropic medications, keep most used items in arms length to prevent bending/reaching, notify therapy of changes in condition, re-inforce need to call for assistance, and move resident closer to nurse station until IDT (Interdisciplinary Team) can evaluate. A weekly nurse progress note, dated 3/19/24 at 9:07 a.m., indicated the resident was alert and oriented x3; needed cueing on date/time. He was able to make his needs known and answer appropriately. His skin was pink, warm, and intact		assessment and MDS updating the care plan on 4/8/24. 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents of the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee in-serviced nursing staff on the policy "Guidelines for Incident/Accidents/Fall" on 4/22/2024. Additionally, any staff that fails to comply with points of this education will be further in-serviced and/or 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. The DON/Designee will complete an audit on falls for identification, assessments, and follow up for change in condition 5 times a week x 4 weeks, then 3 times a	

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	with 2+ pitting edema to both lower extremities and he wore compression socks as ordered. He was independent with transfers and ADL (activities of daily living) care at most times. He ate and drank adequately. His lung sounds were clear on both sides and respirations even and unlabored without shortness of breath. He was calm, pleasant, cooperative and denied pain. A Change in Condition report, dated 3/19/24 at 10:32 p.m., indicated a CNA (Certified Nurse Aid) reported the resident had fallen. His range of motion was assessed and he was checked for injuries and placed back into his recliner chair. His wheelchair had been observed folded up and lying on the floor next to him on side. Resident B indicated he'd needed to use the restroom. He indicated to the nurse, he had hit the right side of his head. The nurse obtained vital signs and neurological checks were initiated. There was no visible injury observed on his head. He was given a dose of Tylenol for a headache with no further complaints. A Late Entry note-dated 3/20/24 at 10:19 a.m., indicated the IDT recommended continuing fall follow up per facility protocol including completing of neurological checks per orders. The resident remained on therapy services, who were updated on the incident and need to review transfer and safety precautions with the resident during sessions. Dycem was placed in the recliner chair in his room and signage placed on whiteboard to aid in cueing the resident to call for assistance. An NP (Nurse Practitioner) note, dated 3/20/24 at 10:30 a.m., indicated the resident had been seen following a fall without injury. The resident reported a mild headache and soreness to the		week x 4 weeks, then once a week x 4 months. If the facility is with 95% compliance at the end of 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. By what date the systemic changes for each deficient will be completed. May 10th, 2024.	

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	back of right side of his head. Resident B indicated the wheelchair had slipped out from underneath him as he transferred on the previous evening and he fell to the floor hitting the back of his head. Staff were to monitor him per facility protocol and notify the NP of any changes. A recommendation was made to consider moving the resident closer to the nurses station and obtaining labs if he continued to fall. An Incident Note, dated 3/24/24 at 5:25 a.m., indicated the resident was observed on the floor laying on his right side. He had a 1 cm (centimeter) laceration to the left side of his nose, a 2 cm laceration to the left side of his forehead, and an abrasion to his right lower back. He was assisted up off the floor and given Tylenol for pain. Neurological checks were initiated without abnormal findings observed. The resident was to be moved to a room closer to the nurses station. A MAR (Medication Administration Record) Administration note, dated 3/24/24 at 9:26 p.m., indicated the resident had been given Tylenol for facial grimacing after being re-positioned. A Late Entry note-dated 3/25/24 at 1:41 p.m., indicated the IDT met regarding the resident's unwitnessed fall. The resident had been moved immediately following the fall to a room closer to the nurses station for increased and frequent monitoring. He was observed with small healing lacerations to his forehead and nose with scabs. He had bruising to both upper extremities and an abrasion to his right lower back. An NP note, dated 3/25/24 at 7:24 p.m., indicated the resident was seen following a fall. He had lacerations to the left side of his nose and left side of forehead and large abrasion to his right			

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	posterior mid back. He was seen sitting in his recliner chair in his room which had been moved closer to the nurses station. He was slightly short of breath. He had a large superficial abrasion to his right posterolateral mid side with bruising and tenderness when touched. He complained of "pain all over" with deep inspiration. He had bruising to his outer right thigh and swelling and bruising to his right knee. Labs and x-rays of chest, right hip and right knee was ordered. A nurse note, dated 3/26/24 at 3:30 a.m., indicated the resident continued with neurological checks and vital signs which were normal. Bruising and abrasions continued with no new injuries observed or reported. -At 9:37 a.m., X-ray results received and no fractures or acute issues were noted. -At 4:11 p.m., the resident continued with bruises from his fall in various stages of healing. No new injuries. A nurse note, dated 3/27/24 at 1:27 a.m., indicated the resident continued on fall follow up. He had no new injuries and continued with bruising to his face, forehead and back. A nurse note, dated 3/28/24 at 4:08 a.m., indicated the resident continued on fall follow up. He continued with "scratches" to left side of his nose and left side of forehead. No new injuries. An NP note, dated 3/29/24 at 9:57 a.m., indicated the resident had been seen eating breakfast in the dining hall with no acute concerns. The bruising was healing to his right knee, right hip, and right thoracic region with associated abrasion. He had scabbed superficial abrasions to his left eyebrow and nose which were healing well. The swelling in his legs was decreasing and had 1+ pitting edema.			

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	Staff were to notify the NP of any acute concerns. MAR notes, dated 3/29 and 3/30/24, indicated the resident's blood pressure was low and anti-hypertensive medications held. A nurse note, dated 3/31/24 at 6:11 a.m., during rounds, the resident was observed with shortness of breath, moist skin, left upper extremity swollen with 2-3+ edema, blood sugar elevated, respirations elevated and heart rate at 134 per minute (normal 60-80). His oxygen saturation (blood level of oxygen) was 71% (normal >90%) and he was administered 4 liters of oxygen. New orders received to send the resident to the ER for evaluation and treatment. On 4/18/24 at 11:54 A.M., the Rehabilitation Director was interviewed. She indicated Resident B had been on their caseload until he was sent to the hospital on 3/31/24. She indicated the resident was receiving services from both physical and occupational therapies. He was walking with physical therapy and working on balance and exercises for his upper extremities with occupational therapy. The Rehabilitation Director indicated after the resident's fall on 3/24/24, the resident hadn't been able to participate in therapy due to pain/discomfort, fatigue, and "not feeling well". She indicated the resident status was discussed during morning meetings. She provided therapy treatment notes which indicated: -3/25/24: Physical therapy note: the resident had fallen yesterday, on 3/24/24, causing injury to his face. He seems more confused and had a decline in tolerance for gait and transfers. Occupational therapy note: treatment held due to resident not feeling well. -3/26 and 3/27/24: Occupational therapy notes: the resident was unable to participate due to fatigue			

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	and not feeling well. Range of motion exercises were completed in his room. -3/27/24: Physical therapy note: The resident complained of feeling fatigued and sore on this day and required much encouragement to try and complete exercises. The Rehabilitation Director indicated no therapy was attempted on 3/28, 3/29, or 3/30/24. On 4/18/24 at 1:29 P.M., RN 5 (Registered Nurse) was interviewed. She indicated when a resident had a fall, a complete head to toe assessment was to be completed and documented in the Risk Management section of the medical record. 4 assessments were to be completed at the time of the fall-pain assessment, skin assessment, fall risk assessment, change in condition assessment, and neurological checks initiated for head injuries or un-witnessed falls. After the initial assessments and incident report were completed, staff were to document every shift for 72 hours, for pain, injuries, changes in condition, and neurological checks. She indicated this charting was done in the nurse progress notes. ADL documentation, dated 3/1 to 3/24/24, indicated the resident required limited assistance of 1 staff member for transfers and bed mobility. On 3/25-3/31/24, the resident was requiring extensive assistance from 1-2 staff members for transfers and bed mobility. At times, he hadn't gotten out of his recliner chair and into bed following the fall on 3/24/24. A MAR, dated March 2024, indicated Resident B had been assessed and given pain medication on 3/19/24 following his first fall and once on 3/24/24 after his 2nd fall. On 4/19/24 at 2:18 P.M., the Director of Nursing			

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	(DON) was interviewed. She indicated after the resident's first fall on 3/19/24, the fall was reviewed by therapy and the resident was to be reminded to ask for assistance. After the resident's 2nd fall on 3/24/24, the resident had been moved closer to the nurses station but she was unable to provide further information on what room he'd been placed into or what further evaluations the IDT had completed for root cause analysis of his falls. The census report for the resident hadn't indicated he had moved rooms. She indicated following a fall, nurses were to document on every shift, the resident's condition including known and new injuries, change in range of motion, pain, etc. for 72 hours and document in the progress notes. A current policy, titled "Guidelines for Incident/Accidents/Fall" was provided by the DON on 4/19/24 at 2:30 P.M., which stated: "Procedure: 1. If a resident is involved in an incident/accident an immediate assessment of the resident will be completed by the nurse...2. In the case of a fall, the resident will have a head to toe assessment to include a pain assessment and assessment as to any changes in their ROM ability/function...8. Documentation of the physical and mental status of the resident involved will be completed each shift (every 8 hours minimally) over at least the next 72 hours or until the resident's condition improves...11. All falls will have a site investigation by appropriate staff in an effort to define the "root cause" of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Each fall needs a new care plan intervention rolled out. Therapy should be involved to some degree in all post fall reviews to offer any input or to determine if a screen or being added to therapy case load is appropriate...."			

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	This tag relates to Complaint IN00431619. 3.1-45(a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview and record review, the facility failed to ensure triggers were identified and resident specific approaches initiated in providing trauma informed care for 1 of 1 resident reviewed (Resident C). Findings include: On 4/18/24 at 2:15 P.M., Resident C was interviewed. She was observed sitting in a wheelchair covered by several blankets with only her head and hands visible. She indicated she was tired of talking about her issues with the facility staff and felt "helpless". She indicated she'd had some trauma with abuse in her past and was very modest. She hadn't wanted staff to completely uncover her when assisting her with personal care and dressing which she alleged, staff did often on the first shift. She alleged an incident had occurred on 4/10/24 where 2 CNA's (Certified Nurse Aide) had come into her room to assist her up from bed. The CNA's threw back her covers and removed her gown, exposing her. She told them to cover her up but alleged the CNA's just	F 0699	F 699 It is the intent of this facility to ensure triggers are identified and resident specific approaches initiated in providing trauma informed care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident C had psycho-social follow up completed by Social Service Director on 4/19/2024 with no negative psychosocial affects noted. 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 that currently reside in the facility have the potential to be affected by the alleged deficient	05/10/2024

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	laughed at her and told her it wasn't a big deal and they were all girls. Resident C indicated she felt exposed and vulnerable and believed staff were ridiculing her because of her need for modesty. When asked, she indicated she had told staff repeatedly, being covered up and not exposed/being modest was very important to her but believed staff thought "it was a joke" and staff "laughed" about her. On 4/18/24 at 3:01 P.M., Resident C's record was reviewed. Diagnoses included paraplegia, diabetes, and post-traumatic stress disorder (PTSD). A level II PASRR (Pre-Admission Screening and Resident Review), indicated the resident had diagnoses of depression, anxiety disorder and PTSD with symptoms of increased worry, irritability, difficulty focusing and choosing not to eat, receive care, or take medications. An Admission MDS (Minimum Data Set) assessment, dated 3/12/24, indicated Resident C's BIMS (Brief Interview Mental Status) score was 14 indicating she had no cognitive impairment. She had several mood indicators including: little interest or pleasure in doing things and poor appetite nearly every day; trouble falling asleep and feeling tired with little energy 7-11 days. She rejected care 1-3 days during the assessment. Resident C was dependent on staff for bathing, dressing, hygiene, toileting, transfers and bed mobility. A Trauma Screening form, dated 3/7/24 at 2:47 p.m., indicated the resident denied abuse but had depressive illness. A Social Services Evaluation, dated 3/8/24, indicated the resident would not open up about her situations or feelings prior to admission which		practice. Social Services completed a diagnosis audit on all residents for Post Traumatic Stress Disorder on 4/19/2024. No other residents found with Post Traumatic Stress Disorder. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The SSD/designee in-serviced staff on Post Traumatic Stress Disorder to include how to identify triggers and approaches specific to residents with Post Traumatic Stress Disorder on 4/19/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or 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. The SSD/Designee will audit residents with Post Traumatic Stress disorder for resident specific triggers and resident specific approached are in place 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 4 months. If the facility is with 95% compliance at the end of 6 months the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any	

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WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 E STATE BLVD FORT WAYNE, IN 46815

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	had included an incident upsetting to her and one which she refused to speak about. She indicated she had family but they were not supportive of her. Care plans, reviewed on 4/18/24 at 3:04 P.M., indicated the following: -3/8/24: The resident triggered a level II PASRR screening due to depression, anxiety and PTSD. Interventions were to encourage family support; provide support for therapies to promote independence, and refer to psych providers. -3/8/24: The resident had a need for adjustment to the facility. She presented with a sad mood and was treated for depression. She had issues with trusting others. This affected her ability and desire to communicate. Interventions included: encourage her to participate in conversations; provide her with situations which gave her control; learn to recognize/help the resident to identify stressors and intervene/remove stressors where possible. On 4/18/24 at 3:30 P.M., the Administrator and Regional Nurse Consultant were interviewed. Both indicated Resident C should've had a care plan put into place to address the resident's PTSD, triggers to avoid re-traumatization, and resident specific interventions to ensure her feelings of emotional/physical safety. The plan should have included maintaining her modesty and privacy during care. On 4/19/24 at 1:30 P.M., CNA 3 was interviewed. She indicated, on 4/10/24 in the morning, she and another staff member went to Resident C's room to provide care. They attempted to help the resident change her gown when the resident got upset.		concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. By what date the systemic changes for each deficient will be completed. May 10th, 2024.	

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	04/19/2024

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

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	She told them she hadn't wanted to be exposed so they kept the old gown up over her while she put her arms in the new gown and then pulled out the old gown. CNA 3 tried to laugh it off so the resident wouldn't feel embarrassed but the resident was angry. The CNA indicated it was the first day she had cared for the resident. She hadn't been aware the resident wanted kept covered at all times as modesty and privacy were extremely important to her. CNA 3 indicated the resident's care plan hadn't indicated her wishes. On 4/19/24 at 2:34 P.M., the Administrator provided a current copy of the facility policy, titled "Trauma Informed Care" which stated: "This policy and procedure describes expectations for the implementation of trauma-informed and trauma-sensitive services...Trauma is defined as an event or ongoing situation that results in extreme stress that overwhelms a person's ability to cope...that subsequently causes intense physical and psychological stress reactions...it is the intention of this facility to deliver trauma informed services which include...establishing a safe environment that feels physically and emotionally safe and minimizes re-traumatization...using an empowerment mode of care that promotes and respects individual's choice and control...supports the development of healthy relationships...building healthy coping skills...providing access to trauma specific services...ensuring holistic service delivery of trauma services and programs...." This tag relates to Complaint IN00432307.			