STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Fort Wayne	1649 Spy Run Avenue Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate neurological assessments were completed for 1 of 1 resident reviewed. (Resident 53)Findings include:Resident 53's record was reviewed on 03/09/2026 at 1:40 PM. Diagnoses included difficulty in walking and muscle weakness.A progress note dated 2/22/2026 at 6:33 AM indicated Resident 53 fell and neurological assessments were initiated.A review of the Neurological assessment dated [DATE] indicated the following:On 02/22/2026 at 5:45 AM, Resident 53's right pupil was non-reactive.On 02/22/2026 at 6:00 AM, Resident 53's right pupil was non-reactive.On 02/22/2026 at 6:15 AM, Resident 53's right pupil was non-reactive.On 02/22/2026 at 6:30 AM, Resident 53's right pupil was non-reactive.On 02/22/2026 at 7:00 AM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 02/22/2026 at 7:30 AM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 02/22/2026 at 8:00 AM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 02/22/2026 at 8:30 AM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 02/22/2026 at 2:30 PM, the assessment indicated the time slot was skipped as Resident 53 refused. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 02/23/2026 at 8:30 AM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 02/23/2026 at 4:30 PM, the assessment indicated the time slot was skipped. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.No documentation indicated the reason for Resident 53's non-reactive pupil. No documentation was located a follow-up assessment was completed or that the physician was notified.A progress note, dated 12/22/2025 at 5:40 AM, indicated Resident 53 fell and neurological assessments were initiated.A review of the Neurological assessment dated [DATE] indicated the following:On 12/22/2025 at 5:30 AM, Resident 53's right pupil was non-reactive.On (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Fort Wayne	1649 Spy Run Avenue Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/22/2025 at 5:45 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 6:00 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 6:15 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 6:45 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 7:15 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 7:45 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 8:15 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 10:15 AM, Resident 53's right pupil was non-reactive.On 12/22/2025 at 12:15 PM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right pupil was nonreactive, and the left pupil was reactive. The assessment indicated Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 12/22/2025 at 2:15 PM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right pupil was nonreactive, and the left pupil was reactive. The assessment indicated Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 12/22/2025 at 4:15 PM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right pupil was nonreactive, and the left pupil was reactive. The assessment indicated Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 12/22/2025 at 8:15 PM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right pupil was nonreactive, and the left pupil was reactive. The assessment indicated Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 12/23/2025 at 8:15 AM, Resident 53's right and left pupil were equal and reactive, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 12/24/2025 at 7:15 AM, the assessment indicated the time slot was skipped as Resident 53 was sleeping. However, the assessment indicated Resident 53's right and left pupil were equal, Resident 53 was alert and his upper and lower motor function were equal and strong. The assessment indicated Resident 53's speech was clear and his face was symmetrical.On 12/24/2025 at 3:15 PM, Resident 53's right pupil was non-reactive.No documentation was located indicating the reason for Resident 53's non-reactive pupil. No documentation was located that a follow-up assessment was completed or that the physician was notified.In an interview, on 03/12/2026 at 2:00 PM, the Director of Nursing (DON) indicated she was unsure why Resident 53's pupil was nonreactive during the assessments completed on 12/22/2025 and 2/22/2026. The DON indicated she was unable to find any additional documentation pertaining to any follow-up regarding the nonreactive pupil. The DON indicated if a pupil is nonreactive during a neurological assessment the facility would notify the doctor or send the resident to the hospital. The DON indicated that in regard to the assessments indicating they were not completed, however an assessment being completed, staff indicated if the resident was asleep when an assessment was supposed to be completed, they would go back and put in what they saw when the resident woke up.In an interview, on 03/13/2026 at 9:34 AM, the DON indicated the facility would not necessarily send a resident to the hospital if they had a non-reactive pupil during a neurological assessment following a fall. The DON indicated it would depend on the type of medication and history of the resident. The DON indicated they would have notified palliative care or the nurse practitioner of the change in eye pupils.In an interview, on 03/13/2026 at 10:29 AM, the Administrator indicated nursing staff were using the previous assessment for neurological assessments when the resident was asleep.At the time of exit, the facility could not provide documentation they notified palliative care or the facility nurse practitioner regarding Resident 53's non-reactive pupil.A current policy, dated 8/29/2025, provided by the Administrator indicated, The nurse documents and reports any pertinent changes in the resident's neurological status immediately to the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Fort Wayne	1649 Spy Run Avenue Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation and interview, the facility failed to ensure proper storage of respiratory supplies for 1 of 1 resident reviewed. (Resident 13)Findings include:During an observation on 03/09/2026 at 9:36 AM, Resident 13 was not in their room. Resident 13's oxygen tubing was observed lying on the floor and the oxygen machine was turned on.During an observation on 03/10/2026 at 9:46 AM, Resident 13 was not in their room. Resident 13's oxygen tubing was observed on an ottoman and the oxygen machine was turned on.Resident 13's record was reviewed on 03/10/2026 at 10:00 AM. Diagnoses included chronic obstructive pulmonary disease (COPD).In an interview, on 03/10/2026 at 9:52 AM, Licensed Practical Nurse (LPN) 2 indicated the oxygen machine should be turned off and the oxygen tubing should have been wrapped and placed in the plastic bag to prevent contamination.A current policy dated 03/03/2026 provided by the facility Administrator indicated, Store oxygen and respiratory supplies in a bag labeled (i.e., resident name) when not in use.410 IAC 16.2-3.1-47 (a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Fort Wayne	1649 Spy Run Avenue Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interviews and record reviewed, the facility failed to ensure non-pharmacological interventions were completed for 1 of 1 resident reviewed. (Resident 13)Findings include:Resident 10's record was reviewed on 3/10/26 at 12:12 PM. Diagnosis included chronic pain syndrome. A review of Resident 10's current Care plan, dated 1/26/26, indicated a focus of pain secondary to diagnosis of spina bifida, chronic pain syndrome, chronic fatigue, protein calorie malnutrition, decreased mobility, history of left Below knee amputation, and generalized muscle weakness. Resident is very tactile sensitive and will complain of extreme pain. Per history, resident reports that she had to cut her hair short secondary to it causing pain when it touched her back. The goals included the resident will verbalize complaints of pain and/or adequate relief of pain with interventions. The interventions indicated administer medications as ordered/indicated, anticipate Resident 13's need for pain relief and respond immediately to any complaint of pain, educate resident and family regarding pain management, evaluate the effectiveness of pain interventions, identify and record previous pain history and management of that pain and impact on function, identify previous response to analgesia including pain relief, side effects and impact on function, notify physician of unrelieved or worsening pain, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal or resistance to care. Observe and report to Nurse any signs and symptoms of non-verbal pain, for example: changes in breathing (noisy, deep/shallow, labored, fast/slow), vocalizations (grunting, moans, yelling out, silence), mood/behavior (changes, more irritable, restless, aggressive, constant motion), face (sad, crying, worried, scared, clenched teeth, grimacing), body (tense, rigid, rocking, curled up, thrashing). Observe and report to nurse when resident has complaints of pain or requests for pain treatment. Observe for probable cause of each pain episode. Remove/limit causes where possible. Observe for side effects of pain medication such as constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Offer non-pharmacological interventions for pain such as position change, quiet environment, back rub, or diversional activities. Pain meds as ordered. Report to nurse any change in usual activity attendance patterns or refusal to attend activities related to signs or symptoms or complained of pain or discomfort. Report to the nurse loss of appetite, refusal to eat and weight loss.A review of physician orders indicated to give Morphine Sulfate Oral Tablet 15 Milligram (MG) Give 1 tablet 15 mg by mouth every 6 hours as needed for pain. A review of the Medication Administration Record (MAR), dated February 2026, indicated Resident 13 received Morphine Sulfate Oral tablet 15 mg for pain as follows:On the 1st at 1:17 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notes. On the 2nd at 5:21 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 4th at 3:015 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 5th at 11:45 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 6th at 12:19 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 8th at 12:30 AM and 3:30 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 10th at 3:17 AM and 2:49 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 11th at 1:34 AM and 12:32 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 12th at 11:00 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notes. On the 13th at 5:00 AM and 1:59 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 15th at 3:00 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Fort Wayne	1649 Spy Run Avenue Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notesOn the 16th at 11:48 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 17th at 2:58 AM and 4:49 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 20th at 12:20 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 21st at 3:00 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 22nd at 1:22 AM and 3:06 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 24th at 4:09 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notes. On the 25th at 5:55 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 26th at 1:39 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 27th at 4:38 AM and 2:00 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesA review of Medication Administration Record (MAR), dated March 2026, indicated Resident 13 received Morphine Sulfate Oral tablet 15 mg for pain as follows:On the 1st at 2:24 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 2nd at 2:06 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 3rd at 3:35 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 8th at 3:35 PM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 9th at 5:50 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesOn the 10th at 12:05 AM. Non-pharmacological interventions were not documented as attempted in the MAR or progress notesIn an interview, on 03/1/2026 at 1:32 PM, the Administrator indicated she was unable to find any non pharmacological interventions for the dates provided.A current facility policy, titled, Pain Management, dated 11/25, was provided by the Administrator on 3/13/26 at 9:45 AM. The policy indicated .Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both 410 IAC 16.2-3.1-37(a)