STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Fort Wayne Skilled Nursing Facility, The	5544 E State Blvd Fort Wayne, IN 46815

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. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure physician orders for anticoagulant (blood thinning) medications were administered and blood test monitoring completed as ordered by the physician for 1 of 3 residents reviewed with anticoagulant therapy (Resident C).Findings include:A report, dated 11/7/25, alleged Resident C had not received Coumadin (blood thinner) as ordered by the physician. This resulted in the resident having fluctuating lab results.On 11/10/25 at 1:04 P.M., Resident C's record was reviewed. Diagnoses included dementia, heart failure, and prosthetic heart valve.A care plan, revised on 7/29/23, indicated Resident C was at risk for abnormal bleeding due to use of anticoagulants (blood thinner). The goal was for his PT/INR blood tests (clotting ability of blood) to remain within therapeutic range (INR between 2.0-3.0). Interventions included monitoring labs/blood tests as ordered, report critical results to physician immediately, and administer medication as ordered at the same time daily.A physician order, dated 5/24/25, indicated to give Warfarin Sodium (Coumadin-blood thinner) oral tablet-give 8 milligrams (mg) by mouth, 1 time a day. PT/INR labs were ordered to be done every Monday and Thursday and the Nurse Practitioner (NP) notified of results.Review of a Medication Administration Record (MAR), dated October 2025, indicated no documented administration of the Coumadin dose on 10/14,10/15, or 10/18/25. There was no documented reason for the missed doses and no documentation the physician/NP had been notified. The MAR, dated October 2025, indicated the PT/INR lab test was held on 10/16/25 and Coumadin 8 mg administered. There was no documented reason for the lab to have been held and no documentation the physician/NP had been notified. On 10/20/25, a PT/INR lab result indicated Resident C's INR was below the expected therapeutic level at 1.7. The MAR, dated October 2025, indicated the resident was administered Coumadin 12 mg on 10/20 and 10/21/25 and 10 mg on 10/22/25 due to the low PT/INR test result on 10/20/25.On 11/12/25 at 11:48 A.M., Licensed Practical Nurse (LPN) 4 was interviewed. LPN 4 indicated Resident C's PT/INR was checked by the facility staff when they had strips for the PT/INR machine. If they were out of test strips, the PT/INR lab would be sent to the hospital for processing. Based on the results of the PT/INR lab results, changes to the residents Coumadin dose would be made, documented in the nurse notes, and initialed when given in the MAR.An article, titled Coumadin, retrieved from Drugs.com on 11/12/25 at 4:00 P.M., indicated it's use was to prevent complications of blood clots associated with heart valve replacements. The article indicated the dosage and administration of Coumadin must be individualized for each patient based on the INR response to the drug. Prescribers were directed to adjust the dose based on the INR blood test and condition being treated, and target INR should be between 2.0-3.0. Coumadin has a narrow therapeutic range affected by other medications and food. The anticoagulant effect of Coumadin persists beyond 24 hours so when a dose is missed, the patient should take the dose as soon as possible on the same day.Current facility policies, provided by the Regional Nurse Consultant on 11/12/25 at 4:20 p.m., titled Guidelines for Physician Orders and Coumadin Monitoring Guidelines indicated all physician orders received pertaining to the resident would be implemented and followed throughout the course of a resident's stay in the facility. Resident's prescribed Coumadin would be monitored through observation and blood testing of Prothrombin time/International Normalized Ratio (PT/INR) as ordered by the physician.This Citation relates to Intake 2663465.3.1-37

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to thoroughly assess injuries following falls, determine root cause of falls, and develop effective interventions to prevent further falls from occurring for 1 of 3 residents reviewed for accidents (Resident H).Findings include:On 11/10/25 at 10:45 A.M., Resident H was observed seated at a table in the lounge, across from the nurse's station. She sat up straight in a Broda chair with her head down on the table. There was no pillow in the chair with her. Staff were across the hall at the nurses station. -At 12:16 P.M., Resident H was observed sitting up when her tray was placed in front of her. Resident H had a red scab across the bridge of her nose and purple/red bruising around her right eye. There was no pillow in the chair with the resident. Staff were walking by in the hall.-At 1:30 P.M., Resident H was seated upright in the Broda chair, in front of a table in the lounge area, with her head down on the table. There was no pillow in the chair with the resident. There were no staff in the area.On 11/12/25 at 9:44 A.M., Resident H was observed sitting straight up in her tilted Broda chair. She was seated in the hallway, across from the nurse's desk. Bruising remained around her right eye with edges of the bruise starting to yellow in color. There was no pillow in the chair with the resident There were no staff present in the hallway, lounge, or nurse's desk. -At 9:52 A.M., the resident remained sitting straight up in the tilted Broda chair. Certified Nurse Aid (CNA) 3 was observed assisting the resident to lie back in the chair. The CNA did not place a pillow in the chair with the resident.-At 10:15 A.M., Resident H was observed lying back in the tilted Broda chair, seated in front of a table in the lounge area across from the nurse's desk. Her eyes were closed, and she appeared to be asleep. There was no pillow in the chair with the resident. No staff were in the area.-At 11:49 A.M., the resident was observed sitting up in her tilted Broda chair in front of the table, with her head on the table. She then picked up her head and grabbed ahold of the tablecloth, pulling it partially off the table and up to her chin. There was no pillow in the chair with the resident. Staff were across the hall, but no one was paying attention to the resident. Resident H's record was reviewed on 11/10/25 at 3:08 P.M. Diagnoses included Alzheimer's dementia.An annual Minimum Data Set (MDS) assessment, dated 8/7/25, indicated Resident H had severely impaired cognition with long and short term memory problems. She had unclear speech, never made herself understood, and sometimes understood others. She had no behaviors or refusals of care. She was non-ambulatory and dependent on staff for all activities of daily living (ADL).Care plans indicated Resident H was receiving hospice services for end stage dementia. She had the potential for falls due to confusion and extensive history of falls. Interventions, revised on 6/26/25, included not leaving the resident unattended in common areas or in her room. A new intervention, dated 11/9/25, was to tilt back Resident H's Broda chair while up.A change in condition form, dated 11/9/25 at 8:00 a.m., indicated Resident H had fallen from her Broda chair. Her nose had been bleeding but was able to be stopped with applied pressure. Neurological (Neuro) checks were started, she was assisted back into the Broda chair and was resting quietly. Hospice staff were notified and indicated they would be out to visit the resident as soon as able. The form indicated, at an unknown time, the hospice nurse had come in to evaluate the resident. The hospice nurse reported another hospice nurse would be in on 11/10/25 to follow up. There were no new orders given.A late entry progress note, dated 11/9/25 at 11:07 a.m., indicated the Interdisciplinary Team (IDT) met and discussed the resident's fall. A new intervention was put in place to tilt the Broda chair back in a reclining position when the resident was up in the chair.A hospice note, dated 11/9/25 at 2:32 p.m., indicated Resident H had a witnessed fall by staff. The resident leaned forward in her Broda chair and tumbled out, hitting her face on the ground. She was unable to say what happened or if she had pain. The bridge of her nose had a small abrasion that bled, a small scab on the bridge of her nose, and a small area of bruising to the inner corner of her right eye. The intervention was to leave the resident at a table with a pillow in front of her as she was known to lean forward in her chair. A Certified Nurse Aid (CNA) placed the resident and her Broda chair in the open, common area.The care plan was not updated with the hospice intervention of placing a pillow in front of Resident H when she sat at the table. Resident H was not observed with a pillow in front of her while seated at a table. Her Broda chair was observed to be tilted back but Resident H was able to sit straight up in the tilted chair and lean forward.A late entry progress note for 11/10/25, dated 11/11/25 at 4:29 p.m., indicated Resident H was alert and oriented to self and was stable. She had eaten her meals with no change in appetite, had shown no signs of pain, and there were no new concerns. There was no documentation of the residents bruise to her right eye.A late entry progress note for 11/9/25, dated 11/11/25 at 4:37 p.m., indicated a nurse had walked by Resident H and observed her on the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to maintain complete and accurate documentation related to falls, hospice services, and anticoagulant therapy for 2 of 4 residents reviewed (Resident H and Resident C).Findings include:1. On 11/10/25 at 12:16 P.M., Resident H was observed with purple/red bruising around her right eye and a red scab across the bridge of her nose. Resident H's record was reviewed on 11/10/25 at 3:08 P.M. Diagnoses included Alzheimer's dementia. The resident was receiving hospice services for end-stage dementia.A care plan indicated Resident H had the potential for falls due to confusion and extensive history of falls. Interventions, revised on 6/26/25, included not leaving the resident unattended in common areas or in her room. A new intervention, dated 11/9/25, was to tilt back Resident H's Broda chair while up.A change in condition form, dated 11/9/25 at 8:00 a.m., indicated Resident H had fallen from her Broda chair. Her nose had been bleeding but was able to be stopped with applied pressure. Neurological (Neuro) checks were started and she was assisted back into the Broda chair and was resting quietly. Hospice staff were notified and indicated they would be out to visit the resident as soon as able. The form indicated, at an unknown time, the hospice nurse had come in to evaluate the resident. The hospice nurse reported another hospice nurse would be in on Monday (11/10/25) to follow up. There were no new orders given.Neither the change in condition form nor progress notes indicated Resident H had bruising to her right eye.A late entry note for 11/9/25 at 11:07 a.m., indicated the Interdisciplinary Team (IDT) had met and discussed Resident H's fall. A new intervention put in place, was to tilt the Broda chair back in a reclining position when the resident was up in the chair to prevent further falls from occurring. There was no further documentation of the fall, fall follow up, or injuries related to the fall on 11/10/25.On 11/10/25 at 2:19 P.M., Licensed Practical Nurse (LPN) 2 was interviewed. LPN 2 indicated Resident H had fallen the day before but had no injuries. She had not done neuro checks because she was told in report, the fall was witnessed, the resident hadn't hit her head, and she'd had no injuries.The Director of Nursing (DON) was interviewed on 11/10/25 at 3:00 P.M. She indicated falls were documented in the facility Risk Management portion of the clinical record, not part of a resident's record. The DON indicated Interdisciplinary Team (IDT) members would meet after a fall occurred to discuss new interventions, documented in resident progress notes. Follow up fall documentation was to be completed for 72 hours following the fall and documented in the residents clinical record.There was no 72 hour follow-up documentation completed in the Resident H's clinical record at the time of interview.A late entry progress note for 11/10/25, dated 11/11/25 at 4:29 p.m., indicated Resident H was alert and oriented to self and was stable. She had eaten her meals with no change in appetite, had shown no signs of pain, and there were no new concerns.The progress note did not indicate Resident H had bruising around her eye.A handwritten copy of a Neurological Checklist, dated 11/9/25 and 11/10/25, indicated neuro checks were to be done every 15 minutes X 1 hour, then every 30 minutes X 2 hours, then every 2 hours X 12 hours, then every 4 hours X 12 hours, then every 8 hours X 3 days, then daily X 4 days. The checklist indicated Neuro checks were not completed on 11/10/25, as required, at 2:45 a.m., 6:45 a.m., or 10:45 a.m.On 11/12/25 at 10:59 A.M., the Administrator indicated hospice notes should be available in resident hospice charts so staff could coordinate care between hospice and the facility. When asked about falls, she indicated, all falls were reviewed, including circumstances surrounding the fall, any injuries, input from all disciplines including hospice staff, to determine the cause of a fall and appropriate, person-centered care interventions put into place. Documentation of incidents/accidents were placed in the Risk Management portion of the clinical record, but were not part of resident records, and used for quality assurance purposes. The Administrator indicated circumstances surrounding a fall, related injuries and notification to families and physicians should be documented in a resident's progress notes in the clinical record.A hospice note, dated 11/9/25 at 2:32 p.m., indicated Resident H had a witnessed fall by staff. The resident leaned forward in her Broda chair and tumbled out, hitting her face on the ground. She was unable to say what happened or if she had pain. The bridge of her nose had a small abrasion that bled, a small scab on the bridge of her nose, and a small area of bruising to the inner corner of her right eye. The intervention was to leave the resident at a table with a pillow in front of her as she is known to lean forward in her chair. The Certified Nurse Aid (CNA) had placed the resident and her Broda chair in the open, common area. Hospice progress notes were not available in Resident H's record. Staff contacted the hospice company to provide the notes. Hospice notes indicated an intervention of placing a pillow in front of the resident when seated in front of a table for her to lie her head down on. The intervention was not in the resident's care plan