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	02/10/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity during verbal interactions for 2 of 4 residents reviewed for resident rights (Resident O and Resident P). Findings include:A report, dated 1/17/26, alleged a Certified Nurse Aid (CNA) spoke harshly to residents, was mean, and loud. It was alleged the CNA yelled and screamed in the hallways and used curse words when speaking with Resident O. 1. On 2/10/26 at 10:09 A.M., Resident O, identified as interviewable, was interviewed in her room. She indicated CNA 6 had repeatedly come to her room and barked out orders at her. The resident indicated CNA 6 yelled at her and would tell her to get up, get dressed, go to the bathroom and go down to eat. CNA 6 always spoke to her in a raised voice, with a harsh tone, and attitude. At times, the resident alleged, CNA 6 would curse at her and her roommate and could be heard cursing out in the hallway. She indicated she had reported CNA 6 to the charge nurse and had told CNA 6 not to come into her room again. When asked, she indicated CNA 6 continued to provide care to her despite her request not to have her in her room or give care. She indicated CNA 6 was disrespectful to her and made her feel like a child. Resident O's record was reviewed on 2/10/26 at 10:49 A.M. Diagnoses included diabetes, anxiety, and bipolar disorder. A quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident O had no cognitive impairment and no behaviors. She was dependent on staff for toileting, personal hygiene, and lower body dressing. She required maximal assistance with showering and putting on/off footwear, and needed moderate assistance with bed mobility and transfers. She was not able to get up, get dressed and go to the bathroom by herself. Care plans, dated 11/26/25, indicated Resident O, at times, would be resistant to care and have difficulty coping due to her bipolar diagnosis. Interventions included emphasize dignity, emphasize soothing, kind, slow and compassionate speech, do not rush or hurry the resident, provide care consistent with the resident's schedule, and use body language communicating patience. The care plans did not indicate the resident's request for certain staff members not to provide her with care. 2. On 2/10/26 at 10:12 A.M., Resident P, identified as being interviewable, was interviewed in her room along with her roommate, Resident O. Resident P indicated she was blind but had great hearing and had overheard CNA 6 yelling at her roommate on several occasions. Resident P indicated the CNA yelled at her as well and she would respond by cursing at the CNA and telling her to get out of her room. Resident P reported her concerns to the charge nurse. She, too, indicated feeling like a child when CNA 6 yelled. She expressed anger and concern for her roommate when she was yelled at and indicated she was very protective of her. When asked, she indicated having overheard CNA 6 yelling and cursing in the hallway multiple times. Resident P indicated she wanted nothing to do with CNA 6 and did not want her giving her care. Resident P's record was reviewed on 2/10/26 at 12:21 P.M. Diagnoses included blindness, dementia, and stroke. She had resided in the facility for several years. An annual MDS assessment, dated 1/8/26, indicated the resident had moderately impaired cognition and severally impaired vision. She had no behaviors and was (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dependent on staff for her activities of daily living. Care plans indicated Resident P had behaviors related to anxiety and mood issues. Interventions included: approach the resident in a calm manner and tell her what you are doing before giving care. The care plans had not indicated the resident's request for certain staff members not to provide her with care. Confidential interviews, conducted during the course of the survey, indicated staff were not always respectful in their interactions with residents. Some staff members were reported to yell in and down the hallways, yell at residents, and curse when providing care. CNA 6 was reported to yell at Resident O, curse and yell in the hallways. On 2/10/26 at 11:18 A.M., the Interim Director of Nursing (DON) was interviewed. The DON indicated she was aware of verbal warnings given by the previous DON regarding CNA 6's attitude and the way she spoke with residents. She indicated there were no formal written warnings in her employee file. The DON indicated she had not been made aware of Resident O and Resident P's wishes to not have CNA 6 care for them. The DON indicated mandatory meetings were being held on this day regarding resident rights, customer service, and expectations for staff and resident interactions. She indicated staff were not to raise their voices/yell or curse at residents. A current facility policy was provided by the Regional Director of Operations on 2/10/26 at 2:31 P.M. The policy, titled Resident Rights indicated Residents would be treated with dignity and respect in full recognition of their individuality. This Citation relates to Intakes 2698956 and 2728536. 3.1-3(t)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a written notice with appeal rights and discharge planning was provided prior to an involuntary discharge for 1 of 3 residents reviewed for discharge (Resident L). Findings include:A report, dated 1/23/26, indicated Resident L was going to be discharged involuntarily. The resident required assistance with his activities of daily living (ADL's) and nursing care for assessment of unstable conditions and frequent hospitalizations. On 2/9/26 at 12:39 p.m., Resident L's record was reviewed. Diagnoses included persistent atrial fibrillation (abnormal heart rhythm), diabetes, and need for personal assistance. An admission Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident L had no cognitive impairment. He was dependent on staff for toileting hygiene and putting on/off footwear. He required maximum assistance with showering, lower body dressing, and personal hygiene. Moderate assistance was required for upper body dressing, and bed mobility. Transfers in/out of a car or van were not attempted due to the residents' condition. Resident L was receiving physical therapy at the time of the assessment. A care plan, dated 11/26/25, indicated the resident's wish was to discharge home and would require community referral for discharge. The resident had the financial and cognitive means to secure an apartment or rent in a by the week motel. Interventions included encourage discussion of feelings/concerns with impending discharge and monitor for anxiety, fear, or distress, evaluate his motivation to return to the community, establish a pre-discharge plan, evaluate progress, and revise plan, participate in therapy and practice skills outside of therapy gym daily. A physician progress note, dated 11/17/25, indicated Resident L was seen for a history and physical. The resident was admitted after a stay in the hospital for abdominal pain and diarrhea. He had been admitted to the hospital for placement as he reported being homeless and unable to care for himself. He was at the facility for continued medical management, physical therapy, and safe discharge. He indicated, prior to hospitalization, he had been living in his car. The plan was to have him work with social services to find a safe discharge. A Consulting Social Worker note, dated 11/17/25, indicated the resident was seen for initial consultation. Resident L was optimistic about getting better and moving to assisted living at some point and was interested in getting Indiana Medicaid. The Social Services Designee (SSD) was told of his interest in Medicaid. A Discharge Planning/Summary, dated 11/19/25 at 11:27 a.m., indicated the Interdisciplinary Team (IDT) met with the resident at bedside. He had received notice that his managed insurance company was no longer going to pay for his care, effective on 11/19/25. They discussed discharge versus staying and paying privately for his room and board. Resident L expressed frustration and need for further medical care related to his back condition. The resident's vehicle had been towed to the facility and was sitting in the parking lot with all his belongings. After his stay at the facility, he was going to move to a pay by the week motel. He was told he could stay at the facility but would need to pay out of pocket for room and board, and coverage of his therapy. The resident indicated he wanted to appeal the insurance decision and understood if he lost the appeal and was in the facility after midnight, he would be responsible for his continued stay out of pocket. The Discharge Planning/Summary meeting hadn't indicated Resident L was physically able to be safely discharged nor had the resident been offered assistance to apply for Medicaid per his wishes on 11/17/25. He was not given a discharge notice at time of the meeting. A Nurse Practitioner (NP) note, dated 11/20/25, indicated the resident was seen for abnormal labs and planned treatment. His condition was to be monitored. A Discharge Planning/Discharge note, dated 11/20/25 at 2:53 p.m., indicated the SSD, Administrator, and Business Office Manager (BOM) met with the resident. He was informed they were (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still waiting on his insurance appeal and wanted to make sure he understood if the appeal was not overturned, his last date of insurance would have been 11/19/25. Resident L indicated he was not physically capable of getting in and out of his vehicle and leave the facility. The BOM explained the facility would need private pay up front to be able to keep him in the facility and keep providing care. The resident indicated he was going to ask a family member for assistance while the IDT, including therapy, would continue to work towards his discharge plans including securing a residence or pay by the week motel. The Discharge Planning/Discharge note hadn't indicated Resident L was physically able to be safely discharged nor had the resident been offered assistance to apply for Medicaid per his wishes on 11/17/25. He was not given a discharge notice at time of the meeting. A Nurse Practitioner note, dated 11/24/25, indicated the resident was seen for a skin infection requiring antibiotic therapy. His condition was to be monitored. A Discharge Planning/Discharge note, dated 12/2/25 at 3:20 p.m., indicated the IDT met with the resident. The resident was notified that a 30 day payment for room/board had arrived from a family member. He was paid up through 12/19/25. They spoke of places to be discharged to, payment for, transportation, and suggestions for utilizing the time left in therapy to get stronger. Resident L was to be discharged on 12/20/25 per plan. The Discharge Planning/Discharge note hadn't indicated Resident L was physically able to be safely discharged nor had the resident been offered assistance to apply for Medicaid per his wishes on 11/17/25. He was not given a discharge notice with opportunity to appeal at time of the meeting but had been told he was discharging on 12/20/25. A Nurse Practitioner note, dated 12/4/25, indicated the resident was seen for altered mental status. Nursing staff indicated the resident had been increasingly confused over the past 2 days. Changes were made to his medications, orders given for a chest x-ray, and nursing staff were to monitor the resident. A Nurse Practitioner note, dated 12/8/25, indicated the resident was seen for follow up to acute mental status changes. His chest x-ray had been concerning for pneumonia and he was started on antibiotics. The resident indicated he was feeling better and his mentation was improving. A Discharge Planning/Discharge note, dated 12/9/25 at 1:53 p.m., indicated the SSD, BOM, and Administrator met with Resident L at bedside. He was informed the check sent by a family member to pay for his care had not been cleared for payment and he owed the facility for care provided since 11/19/25. The note indicated the resident was planning to discharge not willingly. The resident indicated he could not move and get out of bed due to pain. He was told he needed to leave on this date. The Discharge Planning/Discharge note hadn't indicated Resident L was physically able to be safely discharged . There was no physician documentation indicating Resident L was safe to be discharged on 12/9/25 and no plans put into place for the resident to safely discharge. He was not given a discharge notice with the right to appeal the discharge nor had he been offered assistance to apply for Medicaid per his wishes stated on 11/17/25. A Discharge Planning/Summary note, dated 12/9/25 at 3:56 p.m., indicated the resident called 911 and requested transfer to the ER. The EMS arrived and transported him to a local hospital. The hospital social worker was contacted and notified the facility would allow the resident to come back to the facility if he was not admitted to the hospital. Resident L was re-admitted on [DATE] and remains a resident of the facility. On 2/9/26 at 2:22 P.M., the Business Office Manager was interviewed. She had been present during the meetings with the resident which occurred in November and December 2025. She indicated it was not the facility's policy to discharge residents without providing a discharge notice and opportunity to appeal. She indicated the resident had applied for Medicaid and was granted it. Resident L was currently paying his liability as required. A current facility policy was provided by the Regional Director of Operations on 2/10/26 at 2:27 P.M. The policy, titled Transfer and Discharge Policy and Procedure indicated the facility (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would permit each resident to remain in the facility .Non-emergency transfers or discharges would receive a notice 30 days before transfer or discharge .The written notice will include a statement that the resident has the right to appeal the action to the State Department of Health and the name, address and telephone number of the State Long Term Care Ombudsman .The resident may remain in the facility pending an appeal . The deficient practice was corrected on 12/11/25 prior to the start of the survey and was therefore past noncompliance. The facility completed a 30 day look back at facility discharges to ensure adequate notice of discharge and discharge planning was completed, in-serviced management staff and licensed nurses on transfer/discharge procedures; and began audits to monitor discharges for adequate notice and discharge planning. This Citation relates to Intake 2728536. 3.1-12(a)