STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155349	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	1900 Randallia Dr 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to remove discontinued medication from 3 of 3 carts reviewed. (Apple Cart, Moon Cart, and 2nd half of 100 hall cart)Findings include: During an observation, on 1/16/26 at 9:51AM, with Qualified Medication Aid 3 (QMA) the Apple cart had the following discontinued medications; Resident 47 an open bottle of guaifenesin DM, Resident 79 an open bottle of guaifenesin DM, and Resident 91 open bottle of guaifenesin DM.During an observation, on 1/16/26 at 10:07AM, with Licensed Practical Nurse 4 (LPN) the Moon cart had the following discontinued medications; Resident 7 an open bottle of guaifenesin DM, and Resident 74 an open bottle of guaifenesin DM.During an observation, on 1/16/26 at 10:09AM, the second half of the 1st floor cart had the discontinued medication, Amitiza 24mcg, labeled for Resident 51. The medication was at the bottom of the cart.In an interview, on 1/16/26 at 10:15AM, LPN 4 indicated discontinued medications were put in the medication room to be disposed of on third shift.In an interview, on 1/16/26 at 4:00PM, the Assistant Director of Nursing (ADON) indicated she was not sure why the medication (Amitiza) remained at the bottom of the cart. The medication was discontinued on 1/2/26 and should have been returned to pharmacy by third shift. Resident 47's record review began on 1/20/26 at 9:10AM. Resident 47 had an order for guaifenesin DM effective 12/24/25-12/31/25. The medication was discontinued. Resident 79's record review began on 1/20/26 at 9:12AM. Resident 79 had an order for guaifenesin DM effective 6/1/25-6/8/25. The medication was discontinued. Resident 91's record review began on 1/20/26 at 9:15AM. Resident 91 had an order for guaifenesin DM effective 11/11/25-1/5/26. The medication was discontinued. Resident 7's record review began on 1/20/26 at 9:18AM. Resident 7 had an order for guaifenesin DM effective 12/26/25-12/31/25. The medication was discontinued. Resident 74's record review began on 1/20/26 at 9:21AM. Resident 74 had an order for guaifenesin DM effective 12/29/25-1/5/26. The medication was discontinued. In an interview, on 1/20/26 at 11:50AM, the Director of Nursing (DON) indicated many of the orders for the cough syrups were for a week and not active on 1/16/26 when audits of medication carts were performed. A current policy and procedure titled Medication Destruction was provided by the DON on 1/21/26 at 9:15AM. The policy indicated.Discontinued medications as well as medications left in the facility after a resident's discharge, that do not qualify for pharmacy return credit are destroyed.Unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed. 3.1-25(j)(m) and (n)

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
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessment accuracy for 1 of 3 residents reviewed. (Resident 52)Findings include:Resident 52's record was reviewed on 1/13/2025 at 1:35 PM. The matrix indicated Resident 52 had a pressure ulcer- the highest stage was indicated as S.Resident 52's diagnoses included unspecified severe dementia with anxiety, generalized muscle weakness, and difficulty walking.A review of Resident 52's skin check completed on 10/28/2025 indicated Resident 52 had an improving unstageable pressure ulcer.Resident 52's current quarterly MDS, dated [DATE], indicated Resident 52 had an unhealed pressure ulcer and an unstageable deep tissue injury.In an interview, on 1/16/2025 at 2:14 PM, the Assistant Director of Nursing (ADON) indicated she was unsure what a stage S pressure ulcer was and indicated Resident 52 did not have a pressure ulcer. The ADON indicated all of Resident 52's pressure ulcers had resolved.On 1/16/2025 at 2:14 PM, the ADON provided a wound assessment, dated 9/23/2025. The assessment indicated Resident 52's pressure ulcer had been resolved.In an interview, on 01/20/2026 at 11:56 AM, the Director of Nursing (DON) indicated Resident 52 did not have a pressure ulcer. The DON indicated the MDS, dated [DATE], indicated a pressure ulcer had healed. The DON indicated the MDS was incorrect as it was pulling from an old, healed wound. In an interview, on 01/20/2026 at 12:36 PM, the Administrator indicated the facility was experiencing issues with skin and wound information transferring into the MDS correctly. The Administrator indicated the facility had made changes regarding how they documented skin assessments. The Administrator indicated Resident 52 did not have a pressure ulcer.A current policy dated 9/2025, provided by the Administrator, indicated, According to federal regulation facilities conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the state.