STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT FORT WAYNE, THE	4730 E STATE BLVD, FORT WAYNE, , 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: November 5, 6 and 7, 2025 Facility number: 003273 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 10, 2025	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be	R 0217	**Plan of Correction – Tag R217** **Date of completion: on or before December 3, 2025** **Regulation 217:** The Facility failed to obtain signed updated service plans for the following	12/03/2025

	appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review the facility failed to ensure service plans were completed, updated, and signed by the resident or responsible party for 4 of 5 residents		residents: 3,4,8 &10. The Director of Nursing had reassessed resident #3 on October 21st, 25, and residents 4,8 & 10 on October 31st, 25. The DON had sent emails and left voicemails for families to come in and meet to discuss any changes and sign new forms but were not yet completed. The Executive Director had directed the DON to reassess all 32 Residents by November 1, 2025, and to schedule Care Plan meetings with each family. All assessments were completed by October 31, 2025, and requests for care plan meetings were sent to all POA's and Residents on or before October 31, 2025. All service plans had not been signed at the time of annual survey on November 5, 2025. The Executive Director will review the service plans for all residents on November 1, 2025 to ensure all are completed and signed. The Director of Nursing was re-educated on the service plan policy stating that each resident	

	reviewed. (Resident 3, Resident 4, Resident 8, and Resident 10) Findings include: 1. Resident 3's record review, on 11/5/25 at 10:35 AM, indicated their medical diagnosis included unspecified dementia, unspecified severity, without behavioral disturbance. A current service plan dated 4/18/25, was not signed by the resident or responsible party. 2. Resident 4's record review, on 11/5/25 at 10:40 AM, indicated their medical diagnosis included, chronic kidney disease. The record review indicated Resident 4 did not have a service plan. 3. Resident 8's record review, on 11/5/24 at 10:45 AM, indicated their medical diagnosis included hypercholesterolemia, and legal blindness. The current service plan, dated 10/2/25, indicated Resident 8 had a change of condition, but the service plan was not signed by the resident or responsible party. 4. Resident 10's record review, on 11/5/25 at 10:55 AM, indicated their medical diagnosis included unspecified		will be reassessed semi-annually or upon change of condition. New assessments will be reviewed and signed by POA or residents to reflect any changes in services or pricing that may apply every six months. The Executive Director will monitor the service plans once a month for the next 12 months to ensure all service plans are kept up to date and are signed. The ED will implement a service plan tacking log + admission/reassessment workflow checklist by December 1, 2025. Results will be reviewed in our monthly QAPI meetings.	

	dementia, unspecified severity, with behavioral disturbance. The current service plan, dated 10/2/25, indicated Resident 10 had a change of condition, but the service plan was not signed by resident or responsible party. In an interview, on 11/6/25 at 10:25 AM, the Administrator indicated the facility did not have current service plans. She indicated they had been attempting to get service plans resolved, had hired someone specifically to complete the service plans, and have them up to date however they did not have them completed. The Adminstrator further indicated they hired a new Director of Nursing (DON) 4 weeks ago. The DON had been working on scheduling service plan meetings and completing assessments for residents. In an interview, on 11/7/25, at 8:55 AM , the DON indicated when a patient entered hospice or had a change of condition, the facility should update the service plan, and residents or their responsible party should sign them. A current facility policy, titled Service/Care plan, dated 3/13/25, was provided by the Administrator on 11/6/25 at 1:23 PM. The policy indicated..."The service/care plan and any			

	revisions shall include a signature or other authentication by facility and by the resident, or resident's representative, documenting agreement on the services to be provided...." Based on interview and record review the facility failed to ensure service plans were completed, updated, and signed by the resident or responsible party for 4 of 5 residents reviewed. (Resident 3, Resident 4, Resident 8, and Resident 10) Findings include: 1. Resident 3's record review, on 11/5/25 at 10:35 AM, indicated their medical diagnosis included unspecified dementia, unspecified severity, without behavioral disturbance. A current service plan dated 4/18/25, was not signed by the resident or responsible party. 2. Resident 4's record review, on 11/5/25 at 10:40 AM, indicated their medical diagnosis included, chronic kidney disease. The record review indicated Resident 4 did not have a service plan. 3. Resident 8's record review, on 11/5/24 at 10:45 AM, indicated their medical diagnosis included hypercholesterolemia, and legal			

blindness.

The current service plan, dated 10/2/25, indicated Resident 8 had a change of condition, but the service plan was not signed by the resident or responsible party.

4. Resident 10's record review, on 11/5/25 at 10:55 AM, indicated their medical diagnosis included unspecified dementia, unspecified severity, with behavioral disturbance.

The current service plan, dated 10/2/25, indicated Resident 10 had a change of condition, but the service plan was not signed by resident or responsible party.

In an interview, on 11/6/25 at 10:25 AM, the Administrator indicated the facility did not have current service plans. She indicated they had been attempting to get service plans resolved, had hired someone specifically to complete the service plans, and have them up to date however they did not have them completed. The Adminstrator further indicated they hired a new Director of Nursing (DON) 4 weeks ago. The DON had been working on scheduling service plan meetings and completing assessments for residents.

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	or had a change of condition, the facility should update the service plan, and residents or their responsible party should sign them. A current facility policy, titled Service/Care plan, dated 3/13/25, was provided by the Administrator on 11/6/25 at 1:23 PM. The policy indicated..."The service/care plan and any revisions shall include a signature or other authentication by facility and by the resident, or resident's representative, documenting agreement on the services to be provided...."			
R 0353	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(f) (f) The facility shall have a policy that ensures the staff has sufficient information to meet the residents ' needs. Based on interview and record review, the facility failed to maintain current hospital preference information in the emergency file book for 4 of 5 residents reviewed (Resident 7, Resident 11, Resident 12, and Resident 13). Findings include: During a review of the emergency file book on 11/6/25 at 10:36 AM., 4 residents lacked	R 0353	**Plan of Correction – Tag R353** **Regulation:**R353 – Staff has sufficient information to meet the residents' needs. Hospital preference was not listed on the face sheet in the emergency binder for residents 4, 11, 12 & 13. **Date of Completion:**November 7, 2025 On November 7, 2025, the facility immediately adjusted face sheets for affected residents 4, 11, 12, & 13 to reflect their hospital of choice. The new face sheets	11/30/2025

	hospital preference on their emergency file. Resident 7's emergency file did not have a hospital preference listed. Resident 11's emergency file did not have a hospital preference listed Resident 12's emergency file did not have a hospital preference listed Resident 13's emergency file did not have a hospital preference listed In an interview, on 11/6/25 at 12:49 PM, the Director of Nursing indicated she was not sure who was in charge of the emergency file book prior to her employment, but she would ensure the hospital preferences were completed. In an interview, on 11/6/25 at 1:23 PM, the Administrator indicated the facility did not have a policy for the emergency file book. Based on interview and record review, the facility failed to maintain current hospital preference information in the emergency file book for 4 of 5 residents reviewed (Resident 7, Resident 11, Resident 12, and Resident 13).		were placed in our emergency binder. A review of the current residents' face sheets was conducted to identify any other residents who may have been affected by not listing their preferred hospital. No additional residents were found to have hospital preference missing The Director of Nursing (DON) will review and the emergency binder and all resident face sheets upon admission and monthly their after to ensure all hospital preferences are listed and placed in the emergency binder. All nursing and admission staff have been re-educated to list the hospital preference on the face sheet upon admission and to update as needed. Completed November 19, 2025. A new policy has been drafted and will be adopted by 11/30/25. The DON or designee will	

	Findings include: During a review of the emergency file book on 11/6/25 at 10:36 AM., 4 residents lacked hospital preference on their emergency file. Resident 7's emergency file did not have a hospital preference listed. Resident 11's emergency file did not have a hospital preference listed Resident 12's emergency file did not have a hospital preference listed Resident 13's emergency file did not have a hospital preference listed In an interview, on 11/6/25 at 12:49 PM, the Director of Nursing indicated she was not sure who was in charge of the emergency file book prior to her employment, but she would ensure the hospital preferences were completed. In an interview, on 11/6/25 at 1:23 PM, the Administrator indicated the facility did not have a policy for the emergency file book.		conduct monthly audits of the emergency binder to ensure all information is current and complete. This will be done for the next 6 months. Audit results will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Any missing information will be addressed immediately. All corrective actions will be completed by November 30, 2025. The DON is responsible for ongoing compliance.	
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2)	R 0383	**Plan of Correction – Tag R383** **Regulation:**R383 – Mental Health Screening - Deficiency.	11/14/2025

	(g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review the facility failed to ensure a comprehensive care plan was developed with mental health providers for 3 of 5 residents reviewed. (Resident 3, Resident 7, and Resident 8) Findings Include: During entrance conference, on 11/5/25 at 10:58AM, Resident 3, Resident 7, and Resident 8 were identified as having major mental illness. 1) Resident 3's record was reviewed on 11/05/2025 at 11:33 AM. Diagnoses included		Mental Health Service Plans were not present for Residents 3, 7 & 8. **Date of Completion:**on or before November 30, 2025 The Psychiatric Nurse Practitioner was contacted on November 17, 2025, and requested that she write a service plan for residents 3, 7 and & 8 by November 25, 2025. The Director of Nursing will also audit all residents with a Mental Health diagnosis and work with our Psych NP to ensure all service plans will be written or updated to meet the semi-annual requirements by December 1, 2025. After which our DON or designee will continue a monthly audit to keep all mental health service plans current. The DON is responsible for ongoing compliance.	

	psychotic disturbances. A review of Resident 3's current care/service plan dated 04/18/25, did not indicate the resident had a diagnosis of psychotic disturbances. The care/service plan did not indicate goals, interventions or address the diagnosis of psychotic disturbances. . 2) Resident 7's record was reviewed on 11/05/2025 at 11:44 AM. Diagnoses included major depressive disorder. A review of Resident 7's medical record indicated she did not have a current care/service plan related to major depressive disorder. There were no goals to address the diagnosis of major depressive disorder. 3) Resident 8's record was reviewed on 11/05/2025 at 11:33 AM. Diagnoses included major depressive disorder. A review of Resident 8's care/service plan, dated 7/29/24, indicated there were no care/service plans completed for this resident related to the diagnosis of major depressive disorder In an interview, on 11/6/25 at 9:17 AM, the Executive Director (ED) indicated she did not realize individuals with major			

	mental illness required a care plan to address specific needs related to the mental illness. The ED indicated the facility has struggled recently with care/service plans. In an interview, on 11/06/25 at 1:22PM, the ED indicated there was no specific policy or procedure to address care plans for major mental illness. Based on interview and record review the facility failed to ensure a comprehensive care plan was developed with mental health providers for 3 of 5 residents reviewed. (Resident 3, Resident 7, and Resident 8) Findings Include: During entrance conference, on 11/5/25 at 10:58AM, Resident 3, Resident 7, and Resident 8 were identified as having major mental illness. 1) Resident 3's record was reviewed on 11/05/2025 at 11:33 AM. Diagnoses included psychotic disturbances. A review of Resident 3's current care/service plan dated 04/18/25, did not indicate the resident had a diagnosis of psychotic disturbances. The care/service plan did not indicate goals, interventions or address the diagnosis of psychotic disturbances.			

	. 2) Resident 7's record was reviewed on 11/05/2025 at 11:44 AM. Diagnoses included major depressive disorder. A review of Resident 7's medical record indicated she did not have a current care/service plan related to major depressive disorder. There were no goals to address the diagnosis of major depressive disorder. 3) Resident 8's record was reviewed on 11/05/2025 at 11:33 AM. Diagnoses included major depressive disorder. A review of Resident 8's care/service plan, dated 7/29/24, indicated there were no care/service plans completed for this resident related to the diagnosis of major depressive disorder In an interview, on 11/6/25 at 9:17 AM, the Executive Director (ED) indicated she did not realize individuals with major mental illness required a care plan to address specific needs related to the mental illness. The ED indicated the facility has struggled recently with care/service plans.			

	In an interview, on 11/06/25 at 1:22PM, the ED indicated there was no specific policy or procedure to address care plans for major mental illness.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review the facility failed to ensure 5 of 5 residents reviewed had a physician annual health statement (Resident 3, Resident 4, Resident 7, Resident 8 and Resident 10). Findings include: 1) Resident 3's record review, began on 11/5/25 at 11:33 AM, indicated diagnosis included psychotic disturbance and unspecified dementia. Resident 3 did not have an annual health statement to indicate she was free from communicable disease. 2) Resident 4's record review, began on 11/5/25 at 11:24 AM,	R 0409	**Plan of Correction – Tag R409** **Regulation:**R409 – Annual Health Screening - Deficiency. Residents 3, 4, 7, 8 & 10 did not have an annual health statement to indicate the residents were free from communicable diseases. **Date of Completion:**on or before November 30, 2025 The Nurse Practitioner was contacted on November 07, 2025, and requested that she examine and then note that residents 3, 4, 7, 8 & 10 we free from all communicable diseases including TB when she arrived for her next visit November 18, 2025. A review of the current residents will be conducted on November 18, 2025, and all residents that do not have an annual health statement will be	11/30/2025

	indicated diagnosis included chronic kidney disease. Resident 4 did not have an annual physician statement documented to indicate Resident 4 was free from communicable disease. 3) Resident 7's record review, began on 11/5/25 at 11:44 AM, indicated diagnosis included vascular dementia and major depressive disorder. Resident 7 did not have an annual physician statement documented to indicate Resident 7 was free from communicable disease. 4) Resident 8's record review, began on 11/5/25 at 11:58 AM, indicated diagnosis included legal blindness and major depressive disorder. Resident 8 did not have an annual health statemented to document they were free from communicable diseases. 5) Resident 10's record review, began on 11/5/25 at 12:16 PM, indicated diagnosis included unspecified dementia with behavioral disturbances. Resident 10 did not have documentation of an annual health statement to indicate the residnet was free from communicable diseases. In an interview, on 11/5/25 at 10:36 AM, the Executive Director (ED) indicated the		examined by the Nurse Practitioner and a statement will be written and placed in their chart. The Nurse Practitioner will write an annual order for all her residents to examine and update the annual health statement each year to remain in compliance. The Director of Nursing or designee will log each resident with their annual date to ensure all residents' statements are renewed on time. A monthly audit will be done to ensure no one is missing. Audit results will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Any missing reports will be addressed immediately. All corrective actions will be completed by November 30, 2025. The DON is responsible for ongoing compliance.	

nurse practioner never wrote the annual health statements due to not having dates provided from a Director of Nursing (DON).

In an interview, on 11/6/25 at 11:30AM, the DON indicated there were no annual physician statements to document residents were free from communicable diseases.

A policy, was provided on 11/6/25 at 1:22PM, titled "Assessments Reviews and Monitoring". The policy did not address annual health statements.

In an interview, on 11/6/25 at 1:36PM, the ED indicated there were no other policies to address annual health statements.

Based on interview and record review the facility failed to ensure 5 of 5 residents reviewed had a physician annual health statement (Resident 3, Resident 4, Resident 7, Resident 8 and Resident 10).

Findings include:

1) Resident 3's record review, began on 11/5/25 at 11:33 AM, indicated diagnosis included psychotic disturbance and unspecified dementia. Resident 3 did not have an annual health statement to indicate she was free from communicable

	disease. 2) Resident 4's record review, began on 11/5/25 at 11:24 AM, indicated diagnosis included chronic kidney disease. Resident 4 did not have an annual physician statement documented to indicate Resident 4 was free from communicable disease. 3) Resident 7's record review, began on 11/5/25 at 11:44 AM, indicated diagnosis included vascular dementia and major depressive disorder. Resident 7 did not have an annual physician statement documented to indicate Resident 7 was free from communicable disease. 4) Resident 8's record review, began on 11/5/25 at 11:58 AM, indicated diagnosis included legal blindness and major depressive disorder. Resident 8 did not have an annual health statemented to document they were free from communicable diseases. 5) Resident 10's record review, began on 11/5/25 at 12:16 PM, indicated diagnosis included unspecified dementia with behavioral disturbances. Resident 10 did not have documentation of an annual health statement to indicate the residnet was free from communicable diseases.			

	In an interview, on 11/5/25 at 10:36 AM, the Executive Director (ED) indicated the nurse practioner never wrote the annual health statements due to not having dates provided from a Director of Nursing (DON). In an interview, on 11/6/25 at 11:30AM, the DON indicated there were no annual physician statements to document residents were free from communicable diseases. A policy, was provided on 11/6/25 at 1:22PM, titled "Assessments Reviews and Monitoring". The policy did not address annual health statements. In an interview, on 11/6/25 at 1:36PM, the ED indicated there were no other policies to address annual health statements.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin	R 0410	**Plan of Correction – Tag R410** **Regulation:**R410– Infection Control - Non-compliance. Resident 10 had received his first TB screening prior to admission, but there was no record of his second step. **Date of Completion:**on	11/30/2025

	skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review the facility failed to ensure tuberculosis (TB) testing was completed for 1 of 5 residents reviewed. Findings include: Resident 10 ' s record was reviewed on 11/5/2025 at 1:26PM. A TB test was completed on 5/29/2025 at 13:15 prior to Resident 10 being admitted. The results were negative and had a value of 0mm. The second step TB test was not available for review. In an interview, on 11/6/2025 at 11:45 AM, the Director of Nursing (DON) indicated she was only able to locate the TB test completed on 5/29/2025. The DON indicated she was unable to locate any additional TB tests for Resident 10.		or before November 30, 2025 The resident in question has since passed (11-16-25) and we will be unable to complete the process to fulfil this requirement. A review of the current residents will be conducted by our Director of Nursing or designee prior to November 24, 2025, and all residents that do not have a 2 step TB or chest Xray on file will begin the process to meet compliance by November 30, 2025. The Executive Director has given the Director of Nursing the admission policy for new residents. An admission check-off sheet will be implemented by November 18, 2025, to ensure all admission requirements are met. The sheet will be given to both the business office director and the executive director to audit and file in the resident file. The ED and Business Office	

	A current policy titled Tuberculosis Screening dated 02/21/2025 provided by the Administrator indicated, " ...For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test ..." Based on interview and record review the facility failed to ensure tuberculosis (TB) testing was completed for 1 of 5 residents reviewed. Findings include: Resident 10 ' s record was reviewed on 11/5/2025 at 1:26PM. A TB test was completed on 5/29/2025 at 13:15 prior to Resident 10 being admitted. The results were negative and had a value of 0mm. The second step TB test was not available for review. In an interview, on 11/6/2025 at 11:45 AM, the Director of Nursing (DON) indicated she was only able to locate the TB test completed on 5/29/2025. The DON indicated she was unable to locate any additional TB tests for Resident 10. A current policy titled		Director will audit each admission to ensure they have met all requirements, including a 2 step TB or chest Xray as part of the admission process and that those results will be placed in their chart. Audit results will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Any missing results will be addressed immediately. All corrective actions will be completed by November 30, 2025. The ED and DON are responsible for ongoing compliance.	

	Tuberculosis Screening dated 02/21/2025 provided by the Administrator indicated, " ...For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test ..."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREKristine Lundquist	TITLEExecutive Director	(X6) DATE11/19/2025