STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF FORT WAYNE	2116 BUTLER RD, 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: October 6, 7, and 8, 2025 Facility number: 004686 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 9, 2025	R 0000		
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observations,	R 0273	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to have been affected by this deficient practice. DSD was educated on the temperature logs and cleaning the drip pan.	10/30/2025

	interview, and record review the facility failed to ensure three of four refrigerators temperatures were logged consistently, and the range drip pan was maitained. 37 of 37 Residents residing in the facility ate food prepared in the kitchen. Findings include: During an observation, on 10/6/25 at 8:54 AM, there were no temperature logs on the refrigerators used for thawing, drinks, and condiments/leftovers. The drip pan on the range had black substances. Some of the substances were smaller than a pencil eraser and some were larger. There were identifiable scorched noodles well as a tator tot in the drip pan. In an interview, on 10/6/25 at 8:56 AM, the Dietary Manager (DM) indicated there should have been temperatures taken and recorded on each individual refrigerator to ensure holding temperatures were at acceptable levels. The DM indicated the drip pan was cleaned weekly. A review of refrigerator temps, provided by DM, dated September 2025, indicated the following: The thawing refrigerator had no recording sheet available for		2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this deficient practice. DSD and cooks were re-in-service on October 9th on our current policy for Refrigerator and Freezer Temperatures and cleaning the drip pan was added to the daily cleaning schedule. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: Kitchen audit on refrigerator/freezer temperatures and drip pan will be performed by the DSD and cooks weekly for four weeks and biweekly for three months. The purpose of the audit will be to ensure that deficient practices will not be repeated and that all dining practices are within the Cedarhurst policy and procedures. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audit results will be reported and reviewed during QI	

	review. The condiment/leftover refrigerator had no temperature recording sheet available for review. A review of refrigerator temps, provided by DM, dated October 2025, indicated the following: The thawing refrigerator had no temperature recorded for the following dates-1, 2, 3, 4, and 5. The drinks refrigerator had no temperature recorded for dates-1, 2, 3, 4, and 5. The condiments/leftovers refrigerator had no temperature recorded for dates- 1, 2, 3, 4, and 5. Cleaning logs did not indicated there was cleaning of the range drip pan documented or specified on daily or weekly assignments. In an interview, on 10/7/25 at 1:46PM, the DM indicated she was unaware of the make and model of the stove or the cleaning directions for the drip pan. A policy and procedure titled "Refrigerator/Freezer Temperatures" there was no date on the policy, was provided by the Administrator on 10/7/25 at 11:17AM. The policy indicated ..." Dining services will		meetings. The QI committee will determine if continued auditing is necessary based on 3 months of compliance. Monitoring will be ongoing. 5. By what date will the systemic changes be completed? October 30th	

	be responsible for taking temperatures on all kitchen nourishment room refrigerators and freezers, and recording temperatures on temperature report logs daily, during each shift. 2. Each refrigerator and freezer unit in the main kitchen were checked at department opening and before any food product was used for the day ...3. Temperatures of each refrigeration and freezer unit is checked by the staff member who is closing the department for the day ..." A policy and procedure titled "Sanitizing Equipment and Food Contact Surfaces" there was no date on the policy, was provided by the Administrator on 10/7/25 at 11:17AM. The policy indicated ..." Employees shall follow the sanitizing recommendations and procedures for each piece of equipment or food contact surface as discussed in the cleaning guideline and procedure for the specific piece of equipment, or per manufacturer's recommendations ..." Based on observations, interview, and record review the facility failed to ensure three of four refrigerators temperatures were logged consistently, and the range drip pan was maitained. 37 of 37 Residents residing in the facility ate food			

prepared in the kitchen.

Findings include:

During an observation, on 10/6/25 at 8:54 AM, there were no temperature logs on the refrigerators used for thawing, drinks, and condiments/leftovers.

The drip pan on the range had black substances. Some of the substances were smaller than a pencil eraser and some were larger. There were identifiable scorched noodles well as a tator tot in the drip pan.

In an interview, on 10/6/25 at 8:56 AM, the Dietary Manager (DM) indicated there should have been temperatures taken and recorded on each individual refrigerator to ensure holding temperatures were at acceptable levels. The DM indicated the drip pan was cleaned weekly.

A review of refrigerator temps, provided by DM, dated September 2025, indicated the following:

The thawing refrigerator had no recording sheet available for review.

The condiment/leftover refrigerator had no temperature recording sheet available for review.

	A review of refrigerator temps, provided by DM, dated October 2025, indicated the following: The thawing refrigerator had no temperature recorded for the following dates-1, 2, 3, 4, and 5. The drinks refrigerator had no temperature recorded for dates-1, 2, 3, 4, and 5. The condiments/leftovers refrigerator had no temperature recorded for dates- 1, 2, 3, 4, and 5. Cleaning logs did not indicated there was cleaning of the range drip pan documented or specified on daily or weekly assignments. In an interview, on 10/7/25 at 1:46PM, the DM indicated she was unaware of the make and model of the stove or the cleaning directions for the drip pan. A policy and procedure titled "Refrigerator/Freezer Temperatures" there was no date on the policy, was provided by the Administrator on 10/7/25 at 11:17AM. The policy indicated ..." Dining services will be responsible for taking temperatures on all kitchen nourishment room refrigerators and freezers, and recording temperatures on temperature report logs daily, during each shift. 2. Each refrigerator and			

	freezer unit in the main kitchen were checked at department opening and before any food product was used for the day ...3. Temperatures of each refrigeration and freezer unit is checked by the staff member who is closing the department for the day ..." A policy and procedure titled "Sanitizing Equipment and Food Contact Surfaces" there was no date on the policy, was provided by the Administrator on 10/7/25 at 11:17AM. The policy indicated ..." Employees shall follow the sanitizing recommendations and procedures for each piece of equipment or food contact surface as discussed in the cleaning guideline and procedure for the specific piece of equipment, or per manufacturer's recommendations ..."			
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 information in the emergency file book related to hospital preference for 6 of 6	R 0353	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit took place on October 9th to identify all residents who did not have a listed hospital preference. All residents who were identified as not having a hospital preference were updated.	10/30/2025

residents reviewed (Resident 10, Resident 14, Resident 15, Resident 16, Resident 17, and Resident 18).

Findings include:

During a review of the emergency file book on 10/7/25, at 1:55 p.m., 6 residents did not have a hospital preference documented on their emergency file.

Resident 10's emergency file, dated 10/06/25, indicated there was no hospital preference listed.

Resident 14's emergency file, dated 10/6/25, indicated there was no hospital preference listed

Resident 15's emergency file, dated 10/06/25, indicated there was no hospital preference listed

Resident 16's emergency file, dated 10/06/25, indicated there was no hospital preference listed

Resident 17's emergency file, dated 10/06/25, indicated there was no hospital preference listed

Resident 18's emergency file, dated 10/06/25, indicated there was no hospital preference listed

2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents had the potential to be affected by this deficient practice. DON will review the emergency binder weekly to ensure all residents have a hospital preference.

3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:

DON will audit the emergency binder weekly for four weeks and biweekly for three months. The purpose of the audit will be to ensure that deficient practices will not be repeated.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

Audit results will be reported and reviewed during QI meetings. The QI committee will determine if continued auditing is necessary based on 3 months of compliance. Monitoring will be ongoing.

5. By what date will the systemic changes be completed?

	In nn interview, on 10/7/25 at 2:01 PM, the Director of Nursing indicated there should have been a hospital preference listed inthe emergency file. She indicated the facility did not have a policy for the emergency files. Based on interview and record review, the facility failed to maintain current information in the emergency file book related to hospital preference for 6 of 6 residents reviewed (Resident 10, Resident 14, Resident 15, Resident 16, Resident 17, and Resident 18). Findings include: During a review of the emergency file book on 10/7/25, at 1:55 p.m., 6 residents did not have a hospital preference documented on their emergency file. Resident 10's emergency file, dated 10/06/25, indicated there was no hospital preference listed. Resident 14's emergency file, dated 10/6/25, indicated there was no hospital preference listed Resident 15's emergency file, dated 10/06/25, indicated there was no hospital preference listed Resident 16's emergency file,		October 30th	

	dated 10/06/25, indicated there was no hospital preference listed Resident 17's emergency file, dated 10/06/25, indicated there was no hospital preference listed Resident 18's emergency file, dated 10/06/25, indicated there was no hospital preference listed In nn interview, on 10/7/25 at 2:01 PM, the Director of Nursing indicated there should have been a hospital preference listed inthe emergency file. She indicated the facility did not have a policy for the emergency files.			

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 SIGNATUREBelinda Branham	TITLEExecutive Director	(X6) DATE10/29/2025