

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER CROSSINGS AT COVINGTON COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 COVINGTON COMMONS DRIVE, FORT WAYNE, , 46804			
(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. This visit included the Investigation of Intake 470839. Intake 470839- No deficiencies related to the allegations are cited. Survey dates: July 30, and 31 2026 Facility number: 014017 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 3, 2026	R 0000			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean,	R 0144	Community's carpet was professionally cleaned on 8/12/2026. Executive Director emailed	08/30/2026	

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	orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview the facility failed to maintain a homelike environment in three of three common areas observed (South Hall, North Hall, and Dining Room). Findings included: In an interview, on 7/30/26 at 2:05 p.m., the Administrator indicated carpets in common areas had not been cleaned since September 2025 and cleaning was delayed due to potential replacement. During an observation, on 7/31/26 at 8:20 a.m. in the South Hall, the following was noted: - o Traffic patterns with yellowish discoloration throughout the hallway. - o Rooms 1 and 2 had yellowing and threadbare carpet across the doorways. - o Room 3 had a darkened area larger than an 4 CM in diameter. - o Room 11 had threadbare carpet across the entire doorway.		Regional Director of Maintenance and Regional Director of Operations the community's recent 2567, indicating deficiency of R144. Executive Director has requested what needs to be done from the community's side to get carpet replacement project initiated. Community will continue to utilize professional carpet cleaning services, no less quarterly until carpet has been replaced. Date of next carpet cleaning will be presented at each QAPI meeting and recorded in the minutes. Compliance Date: August 30, 2026	
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o Room 14 had a large dark area about 3 feet in diameter.

o Carpet changed to a darker color before rooms 24 and 25 near the entrance/exit.

o Room 30 had a yellow-brown discoloration with missing threads the full width of the doorway.

o Three dark circular areas in the hallway between the scheduler's office and room 34, each larger than 8 CM in diameter.

o The carpet color changed before rooms 35 and 36 near the entrance/exit to dingy and faded.

o From room 39 to the end of the hallway, entryways showed yellowing, except room 53, which had an oblong dark spot nearly the length of the doorway extending outward about 6 inches.

o A dark circular spot about 8 CM in diameter was between rooms 58 and 59.

During an observation, on 7/31/26 at 9:03 a.m. in the Dining Room, stains of varying sizes were noted around each table, along with threadbare tracks into and around the room where wheelchair users sat.

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	In an interview, on 7/31/26 at 9:10 a.m., Resident 12 indicated the carpet should have been replaced long ago, describing it as old, dirty, outdated, dingy, and appearing as though someone had vomited on it in several areas. The resident, who uses a wheelchair, stated some hallway areas had become bumpy due to carpet wear. In an interview, on 7/31/26 at 9:24 a.m., the Maintenance Director indicated the carpets were last cleaned on 9/23/25 and provided a receipt. He believed the carpet had been replaced 2-3 years earlier as a refresh. He indicated residents could request apartment carpet replacement every four to five years and noted challenges in keeping up with spot cleaning. During an observation, on 7/31/26 at 9:30 a.m., in the North Hall the following was noted: - o Two threadbare tracks throughout the hallway resembling black lines from wheelchair use were visible the length of the hall.. - o Circular dark spots larger than 8 CM in diameter was seen in front of rooms 84 and 64 and the club room. - o Yellowing across entire			
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	doorways of rooms 104, 102, 101, 100, 99, 97, 94, 93, 85, 82, 76, 81, 80, 75, 74, 73, 72, 69, 68, 67, 66, 65, 63, and 61 averaged about 2 inches wide and the length of the doorways. o Carpet color changes before rooms 78 and 79 near the entrance/exit to a brighter color. o Nine dark circular spots throughout the hall, each smaller than a silver dollar but darker than other spots. In an interview, on 7/31/26 at 10:24am, the Maintenance Director indicated the carpets in all common areas were replaced on 10/21/20. A policy and procedure provided by the Director of Nursing on 7/31/26 at 9:18 a.m. titled, "Younite Guidebook" was undated. On page 22 the guidebook indicated common areas were to be clean, well appointed, and supportive of resident interaction ...			
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	R 0273	All storage areas within the kitchen, including dry storage, were observed to ensure all items were properly labeled. Items that were not or outside of labeled expiration date were discarded. Dining department team	08/30/2026

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standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure proper labeling, storage and sanitation were maintained in the kitchen during 2 of 2 observations. 72 of 72 residents residing in the facility received food from the kitchen. Findings include: 1. During an initial observation of the kitchen on 07/30/26 at 9:06 AM, the following items were open and undated: 1 bag of egg white noodle, 1 large white Krispie, 1 bag of cheerios, 1 bag of Raisin Bran, 1 bag of granola, 1 bag of Frosted Flakes, 1 container of icing, 1 bag of carrots, 1 bag of celery, 4 individual cups of strawberry ice cream, 2 individual cups of vanilla ice cream, 1 individual cup of fried ice cream, 1 bag of sweet potatoes, 1 frozen chicken tenders, 1 bag of sliced pepperoni, 1 bag of pizza sausage, 1 bag of catfish filets, 1 bag of fried fish, 1 bag of apple turnovers, 1 container of diced tomatoes, and 1 bag of salad. On the bread storage carts the following items did not contain a received date or expiration date: 12 packages of hamburger buns, 5 packages of hot dog buns and 8 packages of sliced bread. In the freezer, the following items were past their	members in the community on 7/30/2026, were immediately re-educated and received documented corrective action. Entire dining department was re-educated on August 5th. Sydney Walker, cook and Corey Martin, lead dietary aide, will complete the course work for Food Protection Managers course through Always Food safe by 8/30/2026. The Executive Director or designee will observe food storage for proper labeling no less than 6 out of 7 days for 30 days. If 95% compliance is achieved, auditing will be reduced to 5 out of 7 days for 60 days. If 95% compliance is achieved, the QAPI committee may consider reduction in audit to no less than 3 out of 7 days for the following quarter; and continued reductions quarterly thereafter, as long as 95% compliance is met. If the 95% threshold is not met, auditing will return to 6 out of 7 days and reduced as described above. The Executive Director or designee will temp the cold foods no less than 18 out of 21 meals weekly for no less than 4 weeks. If 95% compliance is achieved temping practice will be reduced to 14 out of 21 meals weekly for no less than 8 weeks. If 95% compliance is achieved, the QAPI committee	
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	expiration date: 3 muffins with a discard date of 7/26/2026 and 3 individual cups of fried ice cream were open to air and undated. In the prep station the following items were open and undated: 1 container of sliced onion, 1 container of sliced tomato, 2 containers of sliced cheese, 1 container of ham and 1 container of turkey. 1 bag of sliced bread was observed to have a gnat flying inside of it. During an interview, on 7/15/2025 at 9:15 AM, the Dietary Aide (DA) indicated the facility had new staff and have been working with them on labeling in dating. The DA indicated the staff label and date items when opened and indicated the items should have been labeled and dated. 2. During an observation, on 7/30/2025 at 11 AM, the DA attempted to take the temps of 8 plated salads, however they varied in temperature of 51 degrees to 70 degrees. Kitchen staff were observed to be taking plated salads from the refrigerator and giving them to residents in the dining hall. During an observation of the dining hall, on 7/30/2025 at 11:10 AM, 7 residents were observed to have plated chicken salads in front of them. 4 Residents were observed to be		may consider reduction in temping practice to no less than 9 out of 21 meals for the following quarter; and continued reductions quarterly thereafter, as long as 95% compliance is met. If the 95% compliance threshold is not met, auditing will return to 18 out of 21 meals weekly and reduced as described above. Auditing/tempering will continue for no less than 4 quarters; with results presented to the QAPI committee. Compliance Date: August 30, 2026	
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	eating the salad. During an interview, on 7/30/2025 at 11:05 AM, the DA indicated the chicken salad entree was not coming to temp. During an interview, on 7/30/2025 at 11:12 AM, the Dietary Manager indicated staff needed to discard salads that were served to residents in the dining hall and wait until the salads in the refrigerator had reached the correct temperature to serve. A current facility policy, Cold Production dated 3/26, was provided by the Dietary Manager, on 7/30/2026 at 12:55 PM. The policy indicated cold foods must be managed carefully so that food is kept as close to 41 degrees or below throughout the process ... finished product temperature by taking an internal temperature of final product immediately following preparation" A current policy titled, Food Storage (Dry, Refrigerated, and Frozen), was provided by the Director of Nursing on 7/31/26 at 8:26 am. The policy indicated ...all food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded ...leftover contents of cans and prepared food will be stored in			
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	covered, labeled, and dated containers in refrigerators and/or freezers. Once a package is opened it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturers expiration date A current facility policy, Food Expiration and Rotation, dated 10/2025, was provided by the Dietary Manager, on 7/30/2026 at 12:55 PM. The policy indicated to discard any foods that are past expiration, those that do not have a date, or have an illegible date... A current facility policy, Manufacturer Labeling, dated 10/2025, was provided by the Dietary Manager, on 7/30/2026 at 12:55 PM. The policy indicated food items during receiving to ensure the manufacturer labeling is present, intact, legible and within expiration ... food products received expired without required labeling and/or with labeling damaged such that printed information is not legible or is missing in whole or in part must be rejected.			
R 0379	Mental Health Screening - Deficiency	R 0379	Service plans for residents with a major mental health illness, as defined in R378, were audited,	08/30/2026

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410 IAC 16.2-5-11.1(c)

(c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record.

Based on interview and record review the facility failed to ensure a care plan was developed related to Major Mental Illness diagnosis for 3 of 5 residents reviewed. (Resident 4, Resident 7, and Resident 15)

Findings include:

1) Resident 4's record was reviewed on 7/30/26 at 11:33 AM. Diagnoses included Major Depressive disorder (MDD).

A review of Resident 4's current level of care dated 2/5/26 did not include the diagnosis of MDD.

2) Resident 7's record was

to ensure there was a care plan. As audit was being completed, care plan was added as identified as missing.

Director of Nursing and Executive Director reviewed and discussed to verify understanding, the Residential Regulations (410 IAC 16.2-5) for Mental Health Screening (Tags 0378-0386) on August 10, 2026.

Director of Nursing updated internal admission checklist to include: do they have a major mental illness noted upon admission; What is the major mental illness; major mental illness care plan initiated. Executive Director will review and verify care plan is present if needed; checklist will be initialed by ED.

Executive Director or designee with audit service plans for residents that have a major mental illness, utilizing the "Diagnosis Report" from the community's electronic medical record system (Point Click Care/PCC), monthly for 12 months. Audits and checklist must achieve 100% compliance each month, results will be presented at QAPI. If 100% compliance is not achieved "Diagnosis Report" audit will need to be completed after each admission.

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reviewed on 7/30/26 at 11:44 AM. Diagnoses included Major Depressive disorder.

A review of Resident 7's current level of care, dated 3/23/26, did not include the diagnosis of MDD.

3) Resident 14's record was reviewed on 7/30/26 at 1:30 PM. Diagnoses included Major Depressive disorder.

A review of Resident 14's current level of care dated 7/29/26 did not include the diagnosis MDD.

An interview, on 7/31/26 at 9:18 AM, the Director of Nursing indicated the level of care was where the facility would have added the diagnosis, then the diagnosis would come over to the care plan. She indicated, there was no way to add the diagnosis and interventions now.

A current facility policy, titled Behavior Management, dated 2/26, was provided by the Director of Nursing on 7/31/26 at 10:52 AM. The policy indicated... The team would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the residents, and develop a plan of care accordingly. Safety strategies would be

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FORM APPROVED

OMB NO. 0938-0391

implemented immediately if necessary to protect the residents and others from harm. a. atypical behavior would be differentiated from behavior that was dangerous or problematic for the resident(s) or staff, or behavior that signaled underlying distress. b. If the behavior was atypical but not problematic or dangerous and the resident did not appear to be in distress, then the team would monitor for changes but not necessarily intervene to "normalize" the behavior. 2. The service plan would incorporate findings from the evaluation and be consistent with current standards of practice. 3. The residents and/or representatives would be involved in the development and implementation of the service plan. Resident and representative involvement or attempt to include the resident and representative in care planning and treatment would be documented. 4. The residents and/or representative would be informed of the residents' condition as well as the potential risks and benefits of proposed interventions. 5. Interventions would be individualized to provide the highest level of well-being for the residents. 6. Interventions and approaches would be based on evaluation of physical, psychological, and behavioral

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symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior and would be documented on the care plan and modified when appropriate. 7. Non-pharmacological approaches would be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms"			
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 SIGNATUREHeather Reich	TITLEExecutive Director	(X6) DATE08/14/2026	