STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD, FORT WAYNE, , 46845

(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 IN00465233 and Intake IN00465480. Intake IN00465233- Findings are Cited at R064 and R090. Intake IN00465480- No findings related to allegations are cited Survey dates: October 14, 15, and 16, 2025 Facility number: 014512 Residential Census: 126 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 20, 2025	R 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Evergreen Village at Fort Wayne desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective 11/7/2025. Evergreen Village at Fort Wayne is respectfully asking for a desk review on this Plan of Correction.	

R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review the facility failed to ensure freedom from misappropriation of resident funds for 1 of 10 residents reviewed (Resident B). Findings include: During an interview, on 10/14/25 at 10:03 AM, Resident B indicated several months prior, Home Health Aide (HHA) 2 was providing care in her room and discussed being hungry. HHA 2 offered to order some food on Door Dash for herself and Resident B. Resident B indicated HHA 2 took a picture of Resident B's credit card with her permission and used it to pay for their meals at Chick fil-A on that date. She indicated she did not give any further permission for HHA 2 to use her bank card. She indicated HHA 2 continued to use her card to pay for her personal purchases after that date. She indicated she spoke to HHA 2 about stopping	R 0064	Funds were reimbursed by HHA 2 to Resident B All residents have the potential to be affected. No other Residents have been found to be negatively affected. On May 21, 2025, HHA 2 was educated regarding use of resident debit card information and misappropriation. On 10/30/2025 Executive Director conducted in-service education with all staff regarding abuse prevention with emphasis on misappropriation and exploitation. Executive Director or designee will conduct 3 random resident and employee interviews weekly for 4 weeks, monthly x 5 months to identify any risks of misappropriation or exploitation. Variances will be corrected at the time of identification and will be reported to the community’s QAPI committee. The Executive Director will be responsible for the continued compliance of the	11/07/2025

	use of her card and repaying her for the money she had spent several times. She indicated HHA 2 had assured her she would repay the money and stop using her card. She indicated HHA 2 gave her excuses whenever she reminded her to repay her. She indicated HHA 2 did not repay her and a few months after the initial occurrence, resumed using her card. Resident B cancelled her card to prevent further charges and contacted the facility administrator. She indicated she met with the Administrator and HHA 2 a few days later. She indicated she was assured her money would be promptly returned to her. After several days of not receiving her money, Resident B contacted the police and discussed her concerns. She indicated she reviewed her bank statement with the officer who noted the purchases made from HHA 2's Door Dash account. Resident B indicated she intended to press charges against HHA 2 if she were not repaid immediately. She indicated after HHA 2 spoke with the police officer; she repaid her that day. Resident B's record was reviewed on 10/14/25 at 12:45 PM. Diagnoses included cerebral palsy and hypertension.		regulation.	

	A report, titled Allen County Police- Incident Report, dated 5/24/25, provided by the Allen County Police Records Department, on 10/14/25 at 10:52 AM, indicated a Police Officer reported to the facility to investigate a report of unauthorized use of a bank debit card belonging to a vulnerable adult by a caregiver. The report indicated Resident B allowed HHA 2 to use her bank card for a single Door Dash purchase for both on 2/19/25 at Chick- Fil-A for $20.82. She indicated HHA 2 had been using the bank card after that without her permission. Purchases included Dash Pass $9.99 on 2/19/25, Rally's 19.44 on 2/19/25, McDonald's $35.68 on 5/7/25, and Dollar General $26.06 on 5/18/25. Resident B had indicated she cancelled her card and reported the incident to facility staff. She indicated HHA 2 frequently gave excuses as to why she did not pay her back. She indicated if she was not paid back that day, she wished to press charges. The report indicated HHA 2 indicated to the officer she was not aware until facility administration notified her Resident B's bank card was still attached to her Door Dash account. She indicated her family was enroute to the facility to pay Resident B back. In an interview, on 10/14/25 at			

	1:52 PM, the Administrator indicated Resident B came to her and indicated HHA 2 had used her bank card to pay for Door Dash orders. She indicated Resident B had offered HHA 2 the card for use on one occasion and HHA 2 had continued to make unauthorized charges on the card. She indicated she spoke to HHA 2 and she indicated she was not aware the charges were being applied to Resident B's bank card and agreed to pay her back. She indicated she could not find any written records of the interactions and could not remember when the discussions took place. She indicated she was made aware a police report was filed and Resident B was repaid later in that same day. She indicated HHA 2 should not have used Resident B's card. She indicated staff were educated on misappropriation of resident property upon hire and as needed. She indicated an all staff meeting was held after the occurrence to re-educate staff. She indicated she should have reported the occurrence to the Department of Health. In an interview, on 10/15/25 at 10:39 AM, HHA 2 indicated Resident B had asked to her to order food from Chick- Fil-A for both of them and offered her bank card information. She indicated she accidentally			

	placed a few more orders using that card information. She indicated she became aware of the issue when she attempted to use the account on 5/19/25 and the card was declined. She indicated Resident B confronted her the same day. She indicated the facility Administrator contacted her to come to a meeting on 5/20/25. During the meeting she agreed to repay Resident B. She indicated Resident B had called the police on 5/24/25 and she repayed Resident B after the police officer spoke to her about the occurrence. She indicated she had not been informed she should not use a resident's bank card prior to the meeting with the Administrator. A document, titled Employee Orientation, dated 2024, provided by the Administrator on 10/15/25 at 2:09 PM, indicated HHA 2 signed an acknowledgement indicating she had received training on the employee handbook on 3/20/24. A document, titled Employee Handbook, dated January 2024, provided by the Administrator on 10/14/25 at 2:55 PM, indicated employees cannot engage in any form of financial transaction with any resident including making any purchase or receiving any tips, loans, or gratuities of any kind.			

	A current policy titled Abuse and Neglect Prevention, undated, provided by the Administrator on 10/15/25 at 2:09 PM indicated upon report of suspicion of abuse, neglect or exploitation, the employee should be removed from the facility and suspended pending the outcome of an investigation. The policy indicated if the allegation included financial abuse, the incident should be reported to local law enforcement within 24 hours of the occurrence. The policy indicated agencies should also be notified as needed. This citation is related to intake IN00465233 Based on interview and record review the facility failed to ensure freedom from misappropriation of resident funds for 1 of 10 residents reviewed (Resident B). Findings include: During an interview, on 10/14/25 at 10:03 AM, Resident B indicated several months prior, Home Health Aide (HHA) 2 was providing care in her room and discussed being hungry. HHA 2 offered to order some food on Door Dash for herself and Resident B. Resident B indicated HHA 2 took a picture of Resident B's credit card with her permission and used it to			

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R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within	R 0090	Funds were reimbursed by HHA 2 to Resident B All residents have the potential to be affected. Regional Director of Operations re-educated Executive	11/07/2025

	twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.		Director relative to Administration and Management – Deficiency, including, but not limited to the facilities Reportable Events Policy. Executive Director or designee will be responsible for monitoring any potential reportable event and will submit to the appropriate State agency. The Executive Director or designee will be responsible for reviewing all potential reportable events 5 days a week for 1 month, weekly for 2 months and monthly for 3 months. Variances will be corrected at the time of identification and will be reported to the community's QAPI committee. The Executive Director will be responsible for the continued compliance of the regulation.	

	(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review the facility failed to ensure an allegation of misappropriation of resident funds was investigated and reported for 1 of 10 residents reviewed (Resident B). Findings include: During an interview, on 10/14/25 at 10:03 AM, Resident B indicated several months ago Home Health Aide (HHA) 2 was providing care in her room and discussed being hungry. HHA 2 offered to order some food on Door Dash for herself and Resident B. Resident B indicated HHA 2 took a picture of Resident B's credit card with her permission and used it to pay for their meals at Chick fil-A on that date. She indicated she did not give any further			

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R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medication was available to be administered as ordered for 1 of 1 resident reviewed (Resident 6). Findings include: In an interview, on 10/14/25 at 12:50 PM, Resident 6 indicated they had not been medicated for their pain for the entire Memorial Day weekend. Resident 6 indicated living with pain made them feel "down." Resident 6 indicated they were sick over the Memorial Day weekend (5/24-26/25) due to not having their pain medication. Resident 6's record was reviewed on 10/15/25 at 10:15 AM. Diagnoses included rheumatoid arthritis, chronic pain syndrome and major depressive disorder.	R 0297	Resident #6 received medications on June 3, 2025. All residents taking narcotics could be affected by this. Audit completed, no other narcotics were found to be unavailable. Director of Nursing in-serviced the nurses and QMAs on October 31, 2025, on narcotic refill process and use of local pharmacy for urgent medication needs. New process for narcotic ordering: When resident is on last card of medications, nursing will obtain refill script from provider and send to the pharmacy. Director of Nursing will audit medications that are not available using the “Not Available” report weekly x4 weeks then monthly x5 months. Audits will be reviewed monthly at QAPI. QAPI committee will make recommendations and will be reviewed x6 months. Completion date 11/7/2025	11/07/2025

A physician order, dated 4/14/25, indicated Resident 6 was to be administered oxycodone at 8:00 AM, 1:00 PM, 8:00 PM and 1:00 AM.

Resident 6's Medication Administration Record, (MAR) dated 5/1/25 through 5/31/25, indicated the following:

On Tuesday 5/27/25, the medication oxycodone was documented as not available but was on order. Resident 6 had been administered the medication at 1:00 AM and 8:00 AM.

On 5/28/25, 5/29/25, 5/30/25 and 5/31/25, the scheduled doses for Resident 6's pain medication were blank.

In an interview, on 10/16/25 at 11:45 AM, the Director of Nursing (DON) indicated they were aware Resident 6 had not received their pain medication for 5 days at the end of May 2025. The DON indicated the pain medication had been ordered but the staff had not anticipated pharmacy delivery delays related to Memorial Day weekend. The DON indicated narcotic pain medications could not be automatically refilled. The DON indicated the NP had to contact the pharmacy by phone or electronic prescription.

A current facility policy, dated 3/2022, indicated the pharmacy

delivered daily Tuesday through Thursday. The policy indicated the pharmacy was available after hours for medications that couldn't wait until the next business day. The policy indicated the facility could utilize a local pharmacy to fill a prescription that could not wait until the next routine delivery day.

Based on interview and record review, the facility failed to ensure medication was available to be administered as ordered for 1 of 1 resident reviewed (Resident 6).

Findings include:

In an interview, on 10/14/25 at 12:50 PM, Resident 6 indicated they had not been medicated for their pain for the entire Memorial Day weekend. Resident 6 indicated living with pain made them feel "down." Resident 6 indicated they were sick over the Memorial Day weekend (5/24-26/25) due to not having their pain medication.

Resident 6's record was reviewed on 10/15/25 at 10:15 AM. Diagnoses included rheumatoid arthritis, chronic pain syndrome and major depressive disorder.

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	couldn't wait until the next business day. The policy indicated the facility could utilize a local pharmacy to fill a prescription that could not wait until the next routine delivery day.			

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 SIGNATUREEmily Nelson	TITLEExecutive Director	(X6) DATE11/04/2025