STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FORT WAYNE	9210 MAYSVILLE ROAD, 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: February 9, 10, and 11 2026 Facility number: 014576 Residential Census: 86 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 11, 2026	R 0000	The community understands the importance of the corrections and will be working to improve those.	
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.	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • The community immediately reviewed the identified concern related to food and nutritional	04/30/2026

	Based on observation and interview the facility failed to ensure food was stored properly in one of one freezer observed. 86 of 86 residents residing in the facility ate food prepared in the kitchen. Findings include: During an observation, on 2/9/26 at 9:16AM, in the walk in freezer there were 2 separate trays with several battered chicken pieces using paper to separate the layers of the battered chicken pieces. They were not covered and open to air. The Dietary Manager was unaware of the chicken in the freezer not properly stored and stated she would take care of it. There was an open bag of French fries without an open date. The bag was open to air. There was an open bag of cut potatoes without an open date, the bag was open to air. In an interview, on 2/9/26 at 11:06AM, the Dietary Manager indicated the chicken and potatoes were not stored properly and her staff were trained in proper technique. A current policy and procedure titled "Food Storage" was provided by the Director of Nursing on 2/10/26 at 10:50AM. The policy indicated ... 1) Food Service Director will lead training for all kitchen		services. Dietary staff were re-educated on proper meal service procedures and verification of diet orders prior to meal delivery. **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.** • Any resident(s) identified as affected received prompt intervention, including review of dietary needs, physician diet orders, and meal service to ensure compliance with prescribed dietary requirements. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** • Dietary staff were re-educated on proper meal service procedures and verification of diet orders prior to meal delivery. Reinforcement of safe food handling practices and	

	employees on the proper storage and labeling of foods, opened and unopened. 2) Food Service Director will inspect and ensure that all opened foods are properly dated and stored daily ...		temperature monitoring procedures. **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.** • The Executive Director or Dietary Services Director will conduct Weekly audits of diet accuracy and meal service for 4 weeks, then biweekly for 60 days and monthly for 3 months, Ongoing audits and monitoring will continue beyond this date to ensure sustained compliance. **By what date the systemic changes will be completed** • Date this will be completed is 04/30/2026	
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract,	R 0298	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	04/30/2026

	and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure there wsa follow up on pharmacy recommendations for 1 of 5 residents reviewed (Resident 44). Findings included: Resident 44's record was reviewed on 2/9/2026. Diagnoses included Gastro-esophageal reflux disease (GERD) without esophagitis.		• The community immediately reviewed the medication concern identified during the survey. Any resident affected received prompt corrective intervention, including review of physician orders, medication administration records (MARs), and medication storage and handling practices. **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.** • Corrections were made immediately by the director of nursing and adon, to ensure medications were administered and stored in accordance with regulatory requirements. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** • An audit was completed	

	A review of physician orders dated 1/16/2025 indicated to give omeprazole Cap 40 mg with an end date of 1/9/2026. A review of physician orders dated 1/9/2026 indicated to give omeprazole Cap 40 mg with no end date. A review of pharmacy recommendations dated 6/17/2025 indicated Resident 44 took omeprazole 40 mg a proton-pump inhibitor (PPI). Longe term use could lead to an increased risk of Clostridioides difficile, COVID, osteoporosis, pneumonia, bone fractures, kidney disease, heart attacks, vitamin/mineral deficiencies, and dementia. The pharmacy recommended stopping omeprazole 40 mg and starting omeprazole 20 mg. A review of pharmacy recommendations dated 8/19/2025 indicated Resident 44 took omeprazole 40 mg proton-pump inhibitor (PPI). Long term use could lead to an increased risk of Clostridioides difficile, COVID, osteoporosis, pneumonia, bone fractures, kidney disease, heart attacks, vitamin/mineral deficiencies, and dementia. The pharmacy recommended stopping omeprazole 40 mg and starting omeprazole 20 mg. A review of pharmacy		of Current physician medication orders, Medication Administration Records, Medication storage areas and labeling, Expiration dates and controlled medication documentation. **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.** · Implementation of routine medication cart and medication room audits, done by the Director of Nursing and Executive Director. Pharmacy consultant review increased to ensure compliance with storage, labeling, and documentation standards. Improved communication process between pharmacy, nursing, and providers regarding medication changes. Audits will be completed by the Director or Assistant director of nursing, weekly for 4 weeks, biweekly for 3 months, and monthly for 2 months. Ongoing audits and monitoring will	

	recommendations, dated 10/30/2025, indicated Resident 44 took omeprazole 40 mg and long-term use of omepraxole could lead to an increased risk of Clostridioides difficile, COVID, osteoporosis, pneumonia, bone fractures, kidney disease, heart attacks, vitamin/mineral deficiencies, and dementia. The pharmacy recommended switching to famotidine or sucralfate. It was also recommended to switch to pantoprazole, use the lowest effective dose, and trial discontinuation after 8-12 weeks if possible. A review of pharmacy recommendations, dated 12/4/2025, indicated Resident 44 took omeprazole 40 mg. Omeprazole is a proton-pump inhibitor (PPI). Long-term use of omeprazole could lead to an increased risk of Clostridioides Difficile, COVID, osteoporosis, pneumonia, bone fractures, kidney disease, heart attacks, vitamin/mineral deficiencies, and dementia. The pharmacy recommended switching to famotidine or sucralfate. However, if the PPI was needed, it was recommended to switch to pantoprazole, the lowest effective dose, and trial discontinuation after 8-12 weeks if possible. In an interview, on 2/10/2026 at		continue beyond this date to ensure sustained compliance. **By what date the systemic changes will be completed** • Date this will be completed, 04/30/2026	

	1:15 PM, the Director of Nusing (DON) indicated Resident 44 was seeing a physician outside of the facility. The DON indicated there were ongoing issues with the family taking Resident 44 to his doctor's appointments. The DON indicated being unsure if there were any progress notes making the family aware of the pharmacy recommendations. The DON indicated they would not contact Resident 44's outside physician to make them aware of the pharmacy recommendation, as that was outside of their scope. The DON indicated she would confirm whether Resident 44's physician or family had been made aware of the recommendation. In an interview, on 2/10/2026 at 2:45 PM, the DON indicated the facility did not have any documentation notifying Resident 44's physician or family of the pharmacy recommendation. The DON indicated she had been obtaining the pharmacy recommendations and was unaware that she was supposed to sign them and indicate whether the physician agreed or disagreed with the recommendation. The DON indicated she thought the pharmacy completed the recommendations and did not know she was supposed to			

	notify the physician or take further action regarding the pharmacy recommendations. The DON indicated the pharmacy recommendation for omeprazole for Resident 44 had not been completed. At the time of exit, the facility did not provide a policy regarding pharmacy recommendations.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known	R 0356	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • The community immediately reviewed the documentation concerned identified during the survey. Any resident record identified as incomplete, inaccurate, or not properly authenticated was corrected promptly. **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.** • A audit of current resident records was completed to verify, by	02/19/2026

	allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to maintain current information for the emergency file book related to code status, for 7 of 7 residents reviewed (Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, and Resident 58). Findings include: A record review of the emergency file book began on 2/9/26 at 10:05 AM. 7 resident's code statuses, did not match their emergency file sheet. 1. A review of the Resident 52's emergency file sheet, dated 10/26/25, indicated a code status of Do Not Resuscitate (DNR). A review of Resident 52's physician order scope of treatment (POST) indicated to attempt cardiopulmonary resuscitation (CPR). 2. A review of the Resident 53's emergency file sheet, dated 11/17/25, indicated a code status of Full Code. Resident 53's POST indicated DNR. 3. A review of the Resident 54's		the director or nursing. Completeness and organization of resident records was completed. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** • Re-education of nursing and clinical staff on documentation requirements Implementation of a standardized documentation review checklist.Daily clinical review of charting completion by the nurse supervisor or designee. **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.** • The Director of Nursing or front desk will conduct Weekly audits of resident records for 4 weeks, biweekly audits for 3 months, and monthly for 2 months. Ongoing audits and monitoring will continue beyond this date	

	emergency file sheet, dated 10/26/2,5 indicated a code status of Full Code. Resident 54's POST indicated DNR. 4. A review of the Resident 55's emergency file sheet, dated 10/26/25, indicated a code status of DNR. Resident 55's POST indicated to attempt CPR. 5. A review of the Resident 56's emergency file sheet, dated 10/26/25, indicated a code status of Full Code. Resident 56's POST indicated DNR. 6. A review of the Resident 57's emergency file sheet, dated 10/26/25, indicated a code status of DNR. Resident 57's POST indicated to attempt CPR. 7. A review of the Resident 58's emergency file sheet, dated 10/26/2,5 indicated a code status of DNR. Resident 58's POST indicated to attempt CPR. In an interview, on 2/9/26 at 11:21 AM, the Business Office Manager indicated it she was unsure who keps up with the emergency book maybe it was nursing or the concierge. In an interview, on 2/9/26 at 11:05 AM, the Administrator indicated the facility did not have a policy specific for the emergency files/book.		to ensure sustained compliance. **By what date the systemic changes will be completed** This will be completed by 04/30/2026.	

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 SIGNATUREKari Cerutti	TITLEExecutive Director	(X6) DATE03/05/2026