STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/28/2025

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 the Investigation of Intake IN00464227. Intake IN00464227 - State deficiencies related to the allegations are cited at R0240, R0349, R0406, R0407, and R0413. Survey date: August 28, 2025 Facility number: 014576 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 2, 2025	R 0000	To Whom It May Concern, We acknowledge receipt of the findings related to **Intake IN00464227, conducted on August 28, 2025, thehealth, safety, and well-being of our residents remain our highest priority.** **Upon receipt of the survey results, we immediately initiated a comprehensive review and developed a Plan of Correction (PoC) for each cited area.** **We have conducted re-education sessions for all relevant staff, updated our internal monitoring protocols, and established a quality assurance team to oversee compliance efforts.** **We are committed to maintaining compliance and ensuring that all residents receive care and services in a**	

			safe, manner. **Should further clarification be needed, we are available to provide additional documentation or support.** **Kari Cerutti** **Kari Cerutti | Executive Director** **Cedarhurst of Fortwayne** **9210 Maysville Rd** **Email:** kcerutti@cedarhurstliving.com **Main: 260-748-0984 | Direct: 260-440-6066 | Fax: 260-748-0741** **Visit Our Website**	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure care was provided based on individual needs and service plans for 2 of 3 residents reviewed (Resident N and	R 0240	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All impacted residents received a **comprehensive nursing assessment** to determine if any aspect of their care, medication administration, treatments,	10/01/2025

	Resident O). Findings include: A report, dated 8/20/25, alleged insulin was not being given per physician orders and service plans for Resident N and Resident O due to there not being a qualified staff member available to administer the medication. 1. On 8/28/25 at 1:18 P.M., Resident N's record was reviewed. Diagnoses included diabetes and delirium. An Individualized Service Plan (ISP), dated 6/6/25, indicated Resident N required assistance with all aspects of medication management and his medications provided to him daily. A physician order, dated 1/4/25, was for insulin-Lantus Solos injection-inject 30 units subcutaneously 1 time daily for diabetes. A Medication Administration Record (MAR) dated August 2025, indicated Lantus insulin was not given on 8/3, 8/6, 8/10, 8/11, 8/16, 8/17 and 8/22/25 as ordered. The MAR indicated Lantus insulin was a "missed medication" on 8/16 and 8/17/25. The MAR was blank for days 8/3, 8/10, 8/11, and 8/22/25.		therapy, or other services) had been missed, delayed, or inconsistently provided, by don 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 facility-wide audit of **all current resident care plans and physician** **orders** to identify any discrepancies between documented care needs and services provided. A review of **treatment administration records (TARs), medication administration records (MARs),** to confirm timely and accurate delivery of services, Completed by the director of nursing. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. Training in	

	In an interview on 8/28/25 at 1:15PM, the Director of Nursing indicated Lantus insulin was initialed as being given on 8/6/25 but had not been administered. 2. On 8/28/25 at 3:19 P.M., Resident O's record was reviewed. Diagnoses included diabetes and dementia. An Individualized Service Plan (ISP), dated 8/28/25, indicated Resident O resided in a secured memory care community and needed her medications managed and administered by a nurse/QMA. A physician order, dated 12/6/24, was for insulin-Lantus Solos injection-inject 32 units subcutaneously 1 time daily for diabetes. A MAR, dated August 2025, indicated Lantus insulin was not given on 8/3, 8/6, 8/10, 8/13, 8/16, 8/18, and 8/22/25 as ordered. The MAR indicated Lantus insulin was a "missed medication" on 8/16/25. The MAR was blank for days 8/3, 8/6, 8/10, 8/13, 8/18, and 8/22/25. On 8/28/25 at 1:20 P.M., Nurse 2 was interviewed. The nurse indicated after giving a medication to a resident, she would chart her initials in the MAR to indicate the medication had been given. When		proper documentation for when not giving medications and in-services on physician orders and insulin compliance. The Administrator and Director of Nursing will **review audit results weekly**. 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; and By what date the systemic changes will be completed The facility has been implemented to ensure services are provided in accordance with resident needs and care plans. All corrective actions and systemic changes will be fully implemented by DON and Executive Director. **daily for 1 month, weekly for 1 month, biweekly for 2 months, monthly for 2 months.**	

	questioned, she indicated if a "box" on the MAR was left blank and had no initials documented, she would assume the medication had not been given. On 8/28/25 at 1:28 P.M., Qualified Medication Aid (QMA) 3 was interviewed. She indicated she initialed the MAR after administering a medication to a resident. She indicated she would not initial the MAR if another QMA or Director of Nursing (DON) gave the medication, such as insulin, because she was not insulin certified. On 8/28/25 at 2:38 P.M., the DON was interviewed. She indicated staff were to initial the MAR after administering a medication to a resident. The staff initials indicated the medication had been given. When questioned, she indicated if a MAR was blank where staff's initials were to be placed to indicate medication had been given, it would mean the medication had not been administered as ordered. The DON had no policy regarding following physician orders but indicated staff were to administer medications as ordered and per resident's Individualized Service Plans. This Citation relates to Intake IN00464227.			

Based on interview and record review, the facility failed to ensure care was provided based on individual needs and service plans for 2 of 3 residents reviewed (Resident N and Resident O).

Findings include:

A report, dated 8/20/25, alleged insulin was not being given per physician orders and service plans for Resident N and Resident O due to there not being a qualified staff member available to administer the medication.

1. On 8/28/25 at 1:18 P.M., Resident N's record was reviewed. Diagnoses included diabetes and delirium.

An Individualized Service Plan (ISP), dated 6/6/25, indicated Resident N required assistance with all aspects of medication management and his medications provided to him daily.

A physician order, dated 1/4/25, was for insulin-Lantus Solos injection-inject 30 units subcutaneously 1 time daily for diabetes.

A Medication Administration Record (MAR) dated August 2025, indicated Lantus insulin was not given on 8/3, 8/6, 8/10, 8/11, 8/16, 8/17 and 8/22/25 as ordered. The MAR indicated

Lantus insulin was a "missed medication" on 8/16 and 8/17/25. The MAR was blank for days 8/3, 8/10, 8/11, and 8/22/25.

In an interview on 8/28/25 at 1:15PM, the Director of Nursing indicated Lantus insulin was initialed as being given on 8/6/25 but had not been administered.

2. On 8/28/25 at 3:19 P.M., Resident O's record was reviewed. Diagnoses included diabetes and dementia.

An Individualized Service Plan (ISP), dated 8/28/25, indicated Resident O resided in a secured memory care community and needed her medications managed and administered by a nurse/QMA.

A physician order, dated 12/6/24, was for insulin-Lantus Solos injection-inject 32 units subcutaneously 1 time daily for diabetes.

A MAR, dated August 2025, indicated Lantus insulin was not given on 8/3, 8/6, 8/10, 8/13, 8/16, 8/18, and 8/22/25 as ordered. The MAR indicated Lantus insulin was a "missed medication" on 8/16/25. The MAR was blank for days 8/3, 8/6, 8/10, 8/13, 8/18, and 8/22/25.

On 8/28/25 at 1:20 P.M., Nurse

	2 was interviewed. The nurse indicated after giving a medication to a resident, she would chart her initials in the MAR to indicate the medication had been given. When questioned, she indicated if a "box" on the MAR was left blank and had no initials documented, she would assume the medication had not been given. On 8/28/25 at 1:28 P.M., Qualified Medication Aid (QMA) 3 was interviewed. She indicated she initialed the MAR after administering a medication to a resident. She indicated she would not initial the MAR if another QMA or Director of Nursing (DON) gave the medication, such as insulin, because she was not insulin certified. On 8/28/25 at 2:38 P.M., the DON was interviewed. She indicated staff were to initial the MAR after administering a medication to a resident. The staff initials indicated the medication had been given. When questioned, she indicated if a MAR was blank where staff's initials were to be placed to indicate medication had been given, it would mean the medication had not been administered as ordered. The DON had no policy regarding following physician orders but indicated staff were to administer medications as			

	ordered and per resident's Individualized Service Plans. This Citation relates to Intake IN00464227.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to maintain accurately documented medication administration records for 2 of 3 residents reviewed (Resident N and Resident O). Findings include: A report, dated 8/20/25, alleged insulin was being administered by unqualified staff to Resident N and Resident O. 1. On 8/28/25 at 1:18 P.M., Resident N's record was reviewed. Diagnoses included	R 0349	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Residents** **potentially exposed** were **immediately assessed** for signs and symptoms of infection by licensed nursing staff. Any residents exhibiting symptoms received a **physician** **evaluation, diagnostic testing** (as appropriate), and were placed on **transmission-based precautions** following CDC and facility protocols. Residents confirmed or suspected of having an infection were placed in **appropriate isolation**, and the interdisciplinary team ensured that **treatment plans were updated** and closely monitored. **Families and healthcare providers** were notified of any changes in condition or risk exposure. The **Don** reviewed and ensured proper implementation of cleaning, disinfection, and PPE protocols in the areas where exposure occurred.	10/01/2025

	diabetes and delirium. A physician order, dated 1/4/25, was for insulin-Lantus Solos injection-inject 30 units subcutaneously 1 time daily for diabetes. A Medication Administration Record (MAR) dated August 2025, indicated, by staff initials, Lantus insulin had been administered by unqualified staff on 8/1, 8/4, 8/5, 8/7, 8/9, 8/12-8/15, 8/18-8/21, 8/23, 8/24, and 8/26-8/28/25. The MAR had been initialed by Qualified Medication Aid (QMA) 5 and QMA 6 who were not certified to administer insulin. 2. On 8/28/25 at 3:19 P.M., Resident O's record was reviewed. Diagnoses included diabetes and dementia. A physician order, dated 12/6/24, was for insulin-Lantus Solos injection-inject 32 units subcutaneously 1 time daily for diabetes. A MAR, dated August 2025, indicated, by staff initials, Lantus insulin had been administered by unqualified staff on 8/1, 8/4, 8/5, 8/7, 8/9, 8/12, 8/14, 8/15, 8/19-8/21, 8/23, 8/24, and 8/25-8/26/25. The MAR had been initialed by QMA 5 and QMA 6 who were not certified to administer insulin. On 8/28/25 at 2:38 P.M., the		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 identified as potentially exposed will be **Monitored for signs and symptoms of infection,** placed on **precautionary isolation** or enhanced precautions if indicated Provided with **clinical follow-up** and diagnostic testing as needed Affected areas of the facility received **terminal cleaning and disinfection** per CDC guidelines. All direct care staff working with high-risk or exposed residents received **immediate retraining** on: PPE usage Hand hygiene Resident isolation policies and procedures. Resident **care plans** were reviewed and updated where necessary to reflect infection-related risks or monitoring needs 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 and Training** All direct care staff, housekeeping,	

	DON was interviewed. She indicated staff initials in the boxes on the MAR, meant the person who initialed the box, was the one who administered the medication. When questioned if QMA 5 and QMA 6 were certified to administer insulin, she indicated they were not. The DON administered insulin to Resident N and Resident O on the dates/times initialed by QMA 5 and QMA 6. She indicated she should have initialed the MAR rather than the QMA's because they were not certified. She indicated only the staff person who administers a medication should initial the medication had been given. On 8/28/25 at 3:56 P.M., QMA 5 was interviewed. She indicated she had initialed the August MAR for Resident N and Resident O's insulin but hadn't administered the medication herself. The DON had given the medication each day QMA 5 had initialed the MAR. The Citation relates to Intake IN00464227. Based on interview and record review, the facility failed to maintain accurately documented medication administration records for 2 of 3 residents reviewed (Resident N and Resident O). Findings include:		and therapy personnel received **mandatory re-education** on infection prevention protocols, including Proper hand hygiene**,** PPE, Isolation precautions**,** Environmental cleaning and disinfection. 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 and trends will be reported to the Ed and completed by the don, monthly, and immediate corrective action will be taken for any observed deficiencies. **daily for 1 month, weekly for 1 month, biweekly for 2 months, monthly for 2 months.**	

A report, dated 8/20/25, alleged insulin was being administered by unqualified staff to Resident N and Resident O.

1. On 8/28/25 at 1:18 P.M., Resident N's record was reviewed. Diagnoses included diabetes and delirium.

A physician order, dated 1/4/25, was for insulin-Lantus Solos injection-inject 30 units subcutaneously 1 time daily for diabetes.

A Medication Administration Record (MAR) dated August 2025, indicated, by staff initials, Lantus insulin had been administered by unqualified staff on 8/1, 8/4, 8/5, 8/7, 8/9, 8/12-8/15, 8/18-8/21, 8/23, 8/24, and 8/26-8/28/25. The MAR had been initialed by Qualified Medication Aid (QMA) 5 and QMA 6 who were not certified to administer insulin.

2. On 8/28/25 at 3:19 P.M., Resident O's record was reviewed. Diagnoses included diabetes and dementia.

A physician order, dated 12/6/24, was for insulin-Lantus Solos injection-inject 32 units subcutaneously 1 time daily for diabetes.

A MAR, dated August 2025, indicated, by staff initials, Lantus insulin had been administered by unqualified staff on 8/1, 8/4,

	8/5, 8/7, 8/9, 8/12, 8/14, 8/15, 8/19-8/21, 8/23, 8/24, and 8/25-8/26/25. The MAR had been initialed by QMA 5 and QMA 6 who were not certified to administer insulin. On 8/28/25 at 2:38 P.M., the DON was interviewed. She indicated staff initials in the boxes on the MAR, meant the person who initialed the box, was the one who administered the medication. When questioned if QMA 5 and QMA 6 were certified to administer insulin, she indicated they were not. The DON administered insulin to Resident N and Resident O on the dates/times initialed by QMA 5 and QMA 6. She indicated she should have initialed the MAR rather than the QMA's because they were not certified. She indicated only the staff person who administers a medication should initial the medication had been given. On 8/28/25 at 3:56 P.M., QMA 5 was interviewed. She indicated she had initialed the August MAR for Resident N and Resident O's insulin but hadn't administered the medication herself. The DON had given the medication each day QMA 5 had initialed the MAR. The Citation relates to Intake IN00464227.			

R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on interview, and record review, the facility failed to develop and maintain infection control policies and procedures to prevent development and transmission of infectious diseases. This affected 1 of 83 residents residing in the facility (Resident M and Resident P). Findings include: A report, dated 8/20/25, alleged a COVID outbreak was occurring in the facility's secured Memory Care Unit (MCU). The complainant alleged several residents and employees had been tested and found to be positive for COVID infections. It was alleged, only symptomatic residents were to be tested for the virus, personal protective equipment (PPE) was not being provided, and staff who tested positive for the virus were required to work when sick. Resident M had symptoms of COVID and tested positive for the virus. It was alleged, another resident (Resident P) who had resided on the MCU, had	R 0406	**Residents** **potentially exposed** were **immediately assessed** for signs and symptoms of infection by licensed nursing staff. Any residents exhibiting symptoms received a **physician** **evaluation, diagnostic testing** (as appropriate), and were placed on **transmission-based precautions** following CDC and facility protocols. Residents confirmed or suspected of having an infection were placed in **appropriate isolation**, and the interdisciplinary team ensured that **treatment plans were updated** and closely monitored. **Families and healthcare providers** were notified of any changes in condition or risk exposure. The **Don** reviewed and ensured proper implementation of cleaning, disinfection, and PPE protocols in the areas where exposure occurred. 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 identified as potentially exposed	10/06/2025

	recently died due to COVID infection. 1. On 8/28/25 at 11:20 A.M., Resident M's record was reviewed. Diagnoses included dementia. The resident resided on the MCU. A physician order, dated 1/11/24, indicated the resident could be tested, as needed for COVID-19 as determined by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to be necessary. Observations notes indicated: On 8/14/25 at 7:00 a.m., Resident M was coughing and congested throughout the night and morning. She was observed with a runny nose and looked ill. -At 12:45 p.m., Resident M was observed to be "really sick". She had a runny nose, watery and puffy eyes, and hoarse voice. She wasn't eating her lunch. On 8/15/25 at 1:15 p.m., new orders were obtained for Acetaminophen 500 milligram (mg) tablets-take 2 tablets by mouth 3 times per day for 3 days for moderate pain and Allegra 24 hour allergy 180 mg tablets-take 1 tablet by mouth daily for 5 days for runny nose. On 8/16/25 at 1:00 p.m., Resident M was observed to be clammy, with a "very bad" runny		will be **Monitored for signs and symptoms of infection,** placed on **precautionary isolation** or enhanced precautions if indicated Provided with **clinical follow-up** and diagnostic testing as needed Affected areas of the facility received **terminal cleaning and disinfection** per CDC guidelines. All direct care staff working with high-risk or exposed residents received **immediate retraining** on: PPE usage Hand hygiene Resident isolation policies and procedures. Resident **care plans** were reviewed and updated where necessary to reflect infection-related risks or monitoring needs. 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 and Training** All direct care staff, housekeeping, and therapy personnel received **mandatory re-education** on infection prevention protocols, including Proper hand hygiene**,** PPE, Isolation	

	stuffed nose. She had a bad cough and was sneezing frequently. Her eyes were very red and drooping and she was weak with body aches. -At 4:15 p.m., Resident M was tested for COVID and was positive for the virus. The Business Manager gave the "okay" to test the resident. The notes did not reflect a Licensed nurse had assessed the resident or determined COVID-19 testing to be appropriate. 8/22/25 at 1:00 p.m., the resident had been coughing and sneezing all day. She ate only a few bites of her food at lunch. A physician order, dated 8/16/25, was for Paxlovid (medication used to treat COVID infections) x 5 days for COVID infection. 2. On 8/28/25 at 10:39 A.M., Resident P's record was reviewed. Diagnoses included cerebral atherosclerosis and dementia. She was receiving hospice services and resided on the MCU. A hospice report, dated 8/10/25 at 1:57 p.m., indicated hospice staff were contacted due to Resident P coughing. The resident had a worsening cough with copious amounts of mucus. The coughing wasn't occurring		precautions**,** Environmental cleaning and disinfection. 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 and trends will be reported to the Ed and completed by the don, monthly, and immediate corrective action will be taken for any observed deficiencies. **daily for 1 month, weekly for 1 month, biweekly for 2 months, monthly for 2 months.**	

	when eating or drinking. A hospice nurse was assigned to visit the resident for an assessment. -At 2:20 p.m., a hospice Visit Note Report, indicated the resident was seen for her cough. Staff reported the resident had upper respiratory symptoms, since 8/9/25, of cough, congestion and hoarse voice. The cough was productive with clear phlegm. Her respirations were non-labored at rest and her breath sounds were clear. A new order was given for Robitussin cough medicine to be given as needed. -At 8:03 p.m., hospice staff were contacted due to Resident P having trouble breathing and talking. The resident had been given cough medicine as ordered but had much mucous making it difficult for her to breath. Staff reported there were COVID cases in the building. A hospice nurse was assigned to return for a 2nd visit to assess the resident. -At 8:31 p.m., a hospice Visit Note Report, indicated the resident was seen due to difficulty breathing. When the hospice nurse arrived to the facility, Resident P was sleeping but aroused easily. Staff reported the resident's episode of difficulty breathing had			

	resolved. A physician order, dated 1/4/24, indicated the resident could be tested, as needed for COVID-19 as determined by a RN/LPN to be necessary. There was no COVID test documented as being completed for Resident P. On 8/28/25 at 2:38 P.M., the Administrator and Director of Nursing (DON) were interviewed. The DON indicated there had been 1 resident who tested positive for COVID-19 but had recovered. The Administrator indicated Resident M was tested for COVID only because the resident's family had requested it. Both indicated COVID testing was done when families/resident requested it to be done or if ordered by the physician/nurse practitioner. The Administrator indicated there had only been 1 resident who tested positive for COVID so hadn't considered it an "outbreak". Both indicated there was plenty of PPE for staff to use, when needed, but they had no policy/procedures to indicate which PPE should be used for which diseases. There were no policies/procedures for testing other residents or staff who may have been close contacts of Resident M nor was there documentation of staff being tested or ill with the virus. The			

	DON indicated COVID tests and supplies were stored in the medical supply room, accessible to nurses and QMA's, weren't required to be signed out, and could've been used to test other residents and staff. Neither she nor the Administrator were aware of any other residents or staff testing positive for COVID. The Administrator, indicated the facility/company had no specific policies for identifying, managing, or caring for residents with suspected or confirmed COVID infections in the facility. There were no specific policies for use of PPE, isolation, or contact tracing for persons exposed to resident/staff with COVID infection. A current facility policy, titled "Infection Control (General)", was provided by the Administrator on 8/28/25 at 10:00 A.M. The policy indicated "in all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection and are in compliance with the CDC guidelines. Employees are prohibited from working if suffering from a contagious illness while still in the infectious stage. Any Resident or Community personnel known to have a reportable disease as listed in the State or County Health Department regulations will be reported immediately to			

	the local health district authority. The Community will comply with all infection control procedures as directed by the local health authority as a result of the reporting...." Retrieved from https://www.cdc.gov/covid/hcp/infection-control/#cdc_infection_control_impleme-3-setting-specific-considerations for COVID-19 infections, indicated Healthcare facility's should: 1. Establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infections: Ensure everyone is aware of recommended IPC practices in the facility; Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: A positive viral test for SARS-CoV-2, Symptoms of COVID-19, or Close contact with someone with SARS-CoV-2 infection. 2. Implement Source Control Measures such as masks and respirators. 3. Perform SARS-CoV-2 Viral Testing: Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as			

	possible; Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should be tested. 4. Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others: Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. 5. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: policy/procedures for Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection; Patient Placement; Personal Protective Equipment; Visitation; Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection; and Environmental Infection Control. This Citation relates to Intake IN00464227. Based on interview, and record review, the facility failed to develop and maintain infection control policies and procedures to prevent development and transmission of infectious			

diseases. This affected 1 of 83 residents residing in the facility (Resident M and Resident P).

Findings include:

A report, dated 8/20/25, alleged a COVID outbreak was occurring in the facility's secured Memory Care Unit (MCU). The complainant alleged several residents and employees had been tested and found to be positive for COVID infections. It was alleged, only symptomatic residents were to be tested for the virus, personal protective equipment (PPE) was not being provided, and staff who tested positive for the virus were required to work when sick. Resident M had symptoms of COVID and tested positive for the virus. It was alleged, another resident (Resident P) who had resided on the MCU, had recently died due to COVID infection.

1. On 8/28/25 at 11:20 A.M., Resident M's record was reviewed. Diagnoses included dementia. The resident resided on the MCU.

A physician order, dated 1/11/24, indicated the resident could be tested, as needed for COVID-19 as determined by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to be necessary.

	Observations notes indicated: On 8/14/25 at 7:00 a.m., Resident M was coughing and congested throughout the night and morning. She was observed with a runny nose and looked ill. -At 12:45 p.m., Resident M was observed to be "really sick". She had a runny nose, watery and puffy eyes, and hoarse voice. She wasn't eating her lunch. On 8/15/25 at 1:15 p.m., new orders were obtained for Acetaminophen 500 milligram (mg) tablets-take 2 tablets by mouth 3 times per day for 3 days for moderate pain and Allegra 24 hour allergy 180 mg tablets-take 1 tablet by mouth daily for 5 days for runny nose. On 8/16/25 at 1:00 p.m., Resident M was observed to be clammy, with a "very bad" runny stuffed nose. She had a bad cough and was sneezing frequently. Her eyes were very red and drooping and she was weak with body aches. -At 4:15 p.m., Resident M was tested for COVID and was positive for the virus. The Business Manager gave the "okay" to test the resident.			

	The notes did not reflect a Licensed nurse had assessed the resident or determined COVID-19 testing to be appropriate. 8/22/25 at 1:00 p.m., the resident had been coughing and sneezing all day. She ate only a few bites of her food at lunch. A physician order, dated 8/16/25, was for Paxlovid (medication used to treat COVID infections) x 5 days for COVID infection. 2. On 8/28/25 at 10:39 A.M., Resident P's record was reviewed. Diagnoses included cerebral atherosclerosis and dementia. She was receiving hospice services and resided on the MCU. A hospice report, dated 8/10/25 at 1:57 p.m., indicated hospice staff were contacted due to Resident P coughing. The resident had a worsening cough with copious amounts of mucus. The coughing wasn't occurring when eating or drinking. A hospice nurse was assigned to visit the resident for an assessment. -At 2:20 p.m., a hospice Visit Note Report, indicated the resident was seen for her cough. Staff reported the resident had upper respiratory symptoms, since 8/9/25, of cough, congestion and hoarse			

voice. The cough was productive with clear phlegm. Her respirations were non-labored at rest and her breath sounds were clear. A new order was given for Robitussin cough medicine to be given as needed.

-At 8:03 p.m., hospice staff were contacted due to Resident P having trouble breathing and talking. The resident had been given cough medicine as ordered but had much mucous making it difficult for her to breath. Staff reported there were COVID cases in the building. A hospice nurse was assigned to return for a 2nd visit to assess the resident.

-At 8:31 p.m., a hospice Visit Note Report, indicated the resident was seen due to difficulty breathing. When the hospice nurse arrived to the facility, Resident P was sleeping but aroused easily. Staff reported the resident's episode of difficulty breathing had resolved.

A physician order, dated 1/4/24, indicated the resident could be tested, as needed for COVID-19 as determined by a RN/LPN to be necessary.

There was no COVID test documented as being completed for Resident P.

On 8/28/25 at 2:38 P.M., the

	Administrator and Director of Nursing (DON) were interviewed. The DON indicated there had been 1 resident who tested positive for COVID-19 but had recovered. The Administrator indicated Resident M was tested for COVID only because the resident's family had requested it. Both indicated COVID testing was done when families/resident requested it to be done or if ordered by the physician/nurse practitioner. The Administrator indicated there had only been 1 resident who tested positive for COVID so hadn't considered it an "outbreak". Both indicated there was plenty of PPE for staff to use, when needed, but they had no policy/procedures to indicate which PPE should be used for which diseases. There were no policies/procedures for testing other residents or staff who may have been close contacts of Resident M nor was there documentation of staff being tested or ill with the virus. The DON indicated COVID tests and supplies were stored in the medical supply room, accessible to nurses and QMA's, weren't required to be signed out, and could've been used to test other residents and staff. Neither she nor the Administrator were aware of any other residents or staff testing positive for COVID. The Administrator, indicated the facility/company had no specific policies for identifying,			

	managing, or caring for residents with suspected or confirmed COVID infections in the facility. There were no specific policies for use of PPE, isolation, or contact tracing for persons exposed to resident/staff with COVID infection. A current facility policy, titled "Infection Control (General)", was provided by the Administrator on 8/28/25 at 10:00 A.M. The policy indicated "in all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection and are in compliance with the CDC guidelines. Employees are prohibited from working if suffering from a contagious illness while still in the infectious stage. Any Resident or Community personnel known to have a reportable disease as listed in the State or County Health Department regulations will be reported immediately to the local health district authority. The Community will comply with all infection control procedures as directed by the local health authority as a result of the reporting...." Retrieved from https://www.cdc.gov/covid/hcp/infection-control/#cdc_infection_control_impleme-3-setting-specific-considerations for COVID-19 infections, indicated Healthcare			

	facility's should: 1. Establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infections: Ensure everyone is aware of recommended IPC practices in the facility; Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: A positive viral test for SARS-CoV-2, Symptoms of COVID-19, or Close contact with someone with SARS-CoV-2 infection. 2. Implement Source Control Measures such as masks and respirators. 3. Perform SARS-CoV-2 Viral Testing: Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible; Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should be tested. 4. Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others: Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact			

	tracing will be performed. 5. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: policy/procedures for Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection; Patient Placement; Personal Protective Equipment; Visitation; Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection; and Environmental Infection Control. This Citation relates to Intake IN00464227.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and	R 0407	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Residents** **potentially exposed** were **immediately assessed** for signs and symptoms of infection by licensed nursing staff. Any residents exhibiting symptoms received a **physician** **evaluation, diagnostic testing**	10/06/2025

	immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to develop infection control policies/procedures to analyze and track respiratory symptoms. This affected 2 of 23 residents residing on the memory care unit (Resident M and Resident P). Findings include: A report, dated 8/20/25, alleged a COVID outbreak was occurring in the facility's secured Memory Care Unit (MCU). The complainant alleged several residents and employees had been tested and found to be positive for COVID infections. Resident M had respiratory symptoms and tested positive for COVID. Resident P was alleged to have had respiratory symptoms. 1. On 8/28/25 at 11:20 A.M., Resident M's record was reviewed. The resident, who resided on the MCU, had respiratory symptoms and was tested and positive for COVID-19 infection. Observation notes indicated Resident M had respiratory symptoms of cough, congestion, and runny nose through the		(as appropriate), and were placed on **transmission-based precautions** following CDC and facility protocols. Residents confirmed or suspected of having an infection were placed in **appropriate isolation**, and the interdisciplinary team ensured that **treatment plans were updated** and closely monitored. **Families and healthcare providers** were notified of any changes in condition or risk exposure. The **Don** reviewed and ensured proper implementation of cleaning, disinfection, and PPE protocols in the areas where exposure occurred. 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 identified as potentially exposed will be **Monitored for signs and symptoms of infection,** placed on **precautionary isolation** or enhanced precautions if indicated Provided with **clinical follow-up** and diagnostic testing as needed	

	night and morning of 8/14/25. She continued with respiratory symptoms and was tested and found positive for COVID on 8/16/25. She was prescribed a 5 day course of Paxlovid (anti-viral to treat COVID-19). 2. On 8/28/25 at 10:39 A.M., Resident P's record was reviewed. The resident resided on the MCU, was receiving hospice services, developed respiratory symptoms on 8/9/25. The symptoms included cough, congestion, hoarse voice, and difficulty breathing. Resident P had not been tested for COVID-19. A current facility policy, titled "Infection Control (General)", was provided by the Administrator on 8/28/25 at 10:00 A.M. The policy indicated "in all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection and are in compliance with the CDC guidelines. Employees are prohibited from working if suffering from a contagious illness while still in the infectious stage. Any Resident or Community personnel known to have a reportable disease as listed in the State or County Health Department regulations will be reported immediately to the local health district authority. The Community will comply with all infection control procedures		Affected areas of the facility received **terminal cleaning and disinfection** per CDC guidelines. All direct care staff working with high-risk or exposed residents received **immediate retraining** on: PPE usage Hand hygiene Resident isolation policies and procedures. Resident **care plans** were reviewed and updated where necessary to reflect infection-related risks or monitoring needs. 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 and Training** All direct care staff, housekeeping, and therapy personnel received **mandatory re-education** on infection prevention protocols, including Proper hand hygiene**,** PPE, Isolation precautions**,** Environmental cleaning and disinfection. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

	as directed by the local health authority as a result of the reporting...." On 8/28/25 at 2:38 P.M., the Administrator and Director of Nursing (DON) were interviewed. The DON indicated Resident M had been the only resident to test positive for COVID 19 and only resident to have been tested for the virus. The Administrator indicated the resident was tested for COVID only because the resident's family had requested it. Both indicated COVID testing was done when families/resident requested it to be done or if ordered by the physician/nurse practitioner. They had not suspected Resident P of having symptoms of COVID nor had they monitored other residents/staff after Resident M became sick with COVID-19. When asked, the Administrator and DON indicated they had no policy/procedure for monitoring and testing residents with like respiratory symptoms which could indicate transmission of COVID-19 or other infectious respiratory illness. This Citation relates to Intake IN00464227. Based on interview and record review, the facility failed to develop infection control policies/procedures to analyze and track respiratory symptoms.		i.e., what quality assurance program will be put into place Audit results and trends will be reported to the Ed and completed by the don, monthly, and immediate corrective action will be taken for any observed deficiencies. **daily for 1 month, weekly for 1 month, biweekly for 2 months, monthly for 2 months.**	

This affected 2 of 23 residents residing on the memory care unit (Resident M and Resident P).

Findings include:

A report, dated 8/20/25, alleged a COVID outbreak was occurring in the facility's secured Memory Care Unit (MCU). The complainant alleged several residents and employees had been tested and found to be positive for COVID infections. Resident M had respiratory symptoms and tested positive for COVID. Resident P was alleged to have had respiratory symptoms.

1. On 8/28/25 at 11:20 A.M., Resident M's record was reviewed. The resident, who resided on the MCU, had respiratory symptoms and was tested and positive for COVID-19 infection.

Observation notes indicated Resident M had respiratory symptoms of cough, congestion, and runny nose through the night and morning of 8/14/25. She continued with respiratory symptoms and was tested and found positive for COVID on 8/16/25. She was prescribed a 5 day course of Paxlovid (anti-viral to treat COVID-19).

2. On 8/28/25 at 10:39 A.M., Resident P's record was reviewed. The resident resided

on the MCU, was receiving hospice services, developed respiratory symptoms on 8/9/25. The symptoms included cough, congestion, hoarse voice, and difficulty breathing. Resident P had not been tested for COVID-19.

A current facility policy, titled "Infection Control (General)", was provided by the Administrator on 8/28/25 at 10:00 A.M. The policy indicated "in all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection and are in compliance with the CDC guidelines. Employees are prohibited from working if suffering from a contagious illness while still in the infectious stage. Any Resident or Community personnel known to have a reportable disease as listed in the State or County Health Department regulations will be reported immediately to the local health district authority. The Community will comply with all infection control procedures as directed by the local health authority as a result of the reporting...."

On 8/28/25 at 2:38 P.M., the Administrator and Director of Nursing (DON) were interviewed. The DON indicated Resident M had been the only resident to test positive for COVID 19 and only resident to

	have been tested for the virus. The Administrator indicated the resident was tested for COVID only because the resident's family had requested it. Both indicated COVID testing was done when families/resident requested it to be done or if ordered by the physician/nurse practitioner. They had not suspected Resident P of having symptoms of COVID nor had they monitored other residents/staff after Resident M became sick with COVID-19. When asked, the Administrator and DON indicated they had no policy/procedure for monitoring and testing residents with like respiratory symptoms which could indicate transmission of COVID-19 or other infectious respiratory illness. This Citation relates to Intake IN00464227.			
R 0413	Infection Control - Deficiency 410 IAC 16.2-5-12(j) (j) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident only to the degree needed to isolate the infecting organism. Based on interview and record review, the facility failed to ensure a resident with an	R 0413	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	10/06/2025

	infectious respiratory illness was isolated to prevent the spread of infection for 1 of 3 residents reviewed (Resident M). Findings include: On 8/28/25 at 11:20 A.M., Resident M's record was reviewed. Diagnoses included dementia. The resident resided on the Memory Care Unit (MCU). Observations notes indicated: On 8/14/25 at 7:00 a.m., Resident M was coughing and congested throughout the night and morning. She was observed with a runny nose and looked ill. -At 12:45 p.m., Resident M was observed to be "really sick". She had a runny nose, watery and puffy eyes, and hoarse voice. She wasn't eating her lunch. No vital signs were documented in the record.		Community documents any symptomatic illnesses to be able to provide and prevent spread of infection. Enforce proper use of PPE, Hand hygiene or isolation procedures. 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. Don and Ed to Retrain all staff on relevant infection control protocols. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.	

	On 8/15/25 at 1:15 p.m., new orders were obtained for Acetaminophen 500 milligram (mg) tablets-take 2 tablets by mouth 3 times per day for 3 days for moderate pain and Allegra 24 hour allergy 180 mg tablets-take 1 tablet by mouth daily for 5 days for runny nose. There was no order for isolation and no evidence the facility had placed the resident in isolation to prevent the spread of infection. On 8/16/25 at 1:00 p.m., Resident M was observed to be clammy, with a "very bad" runny stuffed nose. She had a bad cough and was sneezing frequently. Her eyes were very red and drooping and she was weak with body aches. No vital signs were documented in the record. There was no documentation the residnet had been placed in isolation of rher symptoms. -At 4:15 p.m., Resident M was tested for COVID and was positive for the virus. The Business Manager gave the "okay" to test the resident. On 8/22/25 at 1:00 p.m., the resident had been coughing and sneezing all day. She ate only a few bites of her food at lunch. A physician order, dated 8/16/25, was for Paxlovid (medication used to treat		Ed and Don policy and procedures review, reflect current cdc/cms/isdh guidelines, Facility infection updated policies to reflect current CDC guidance. 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. **Audits will** **be performed by the DON and Executive Director. Audit results will be reported** **and reviewed by the DON and Ed; they** will track compliance to identify patterns and take corrective action as needed. Infection prevention training will also be incorporated into new employee orientation and reinforced during regular in-services. The Administrator and Director of Nursing will be responsible for ensuring continued compliance with infection control policies. **Daily for 1** **month, weekly for 1 month, biweekly for 2 months, monthly for 2 months.**	

COVID infections) x 5 days for COVID infection.

Documentation from 8/14/25 through 8/21/25 did not indicate Resident M had been placed in transmission based precautions and isolated to her room while symptomatic with COVID-19 respiratory symptoms.

On 8/28/25 at 2:38 P.M., the Administrator and Director of Nursing (DON) were interviewed. Both indicated the facility had no policy for isolation of residents with infectious disease which could be transmitted to other residents, staff, and visitors. The DON and Administrator indicated Resident M was dependent on staff and sat in a Broda chair. They indicated staff took the resident to and from her room and dining room. They believed the resident had been kept in her room while having symptoms and feeling sick but had no documentation to provide indicating this.

A current facility policy, titled "Infection Control (General)", was provided by the Administrator on 8/28/25 at 10:00 A.M. The policy indicated "in all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection and are in compliance with the CDC guidelines. Employees are

prohibited from working if suffering from a contagious illness while still in the infectious stage. Any Resident or Community personnel known to have a reportable disease as listed in the State or County Health Department regulations will be reported immediately to the local health district authority. The Community will comply with all infection control procedures as directed by the local health authority as a result of the reporting...." The Administrator, indicated the facility/company had no specific policies for identifying, managing, or caring for residents with suspected or confirmed COVID infections in the facility. The policy had not indicated when/if residents should be placed in isolation, infectious diseases isolation was required for or how long the isolation would last and the resident no longer able to transmit the infection to others.

This Citation refers to Intake IN00464227.

Based on interview and record review, the facility failed to ensure a resident with an infectious respiratory illness was isolated to prevent the spread of infection for 1 of 3 residents reviewed (Resident M).

Findings include:

On 8/28/25 at 11:20 A.M.,

Resident M's record was reviewed. Diagnoses included dementia. The resident resided on the Memory Care Unit (MCU).

Observations notes indicated:

On 8/14/25 at 7:00 a.m., Resident M was coughing and congested throughout the night and morning. She was observed with a runny nose and looked ill.

-At 12:45 p.m., Resident M was observed to be "really sick". She had a runny nose, watery and puffy eyes, and hoarse voice. She wasn't eating her lunch. No vital signs were documented in the record.

On 8/15/25 at 1:15 p.m., new orders were obtained for Acetaminophen 500 milligram (mg) tablets-take 2 tablets by mouth 3 times per day for 3 days for moderate pain and Allegra 24 hour allergy 180 mg tablets-take 1 tablet by mouth daily for 5 days for runny nose. There was no order for isolation and no evidence the facility had placed the resident in isolation to prevent the spread of infection.

On 8/16/25 at 1:00 p.m., Resident M was observed to be clammy, with a "very bad" runny stuffed nose. She had a bad cough and was sneezing frequently. Her eyes were very red and drooping and she was

weak with body aches. No vital signs were documented in the record. There was no documentation the residnet had been placed in isolation of rher symptoms.

-At 4:15 p.m., Resident M was tested for COVID and was positive for the virus. The Business Manager gave the "okay" to test the resident.

On 8/22/25 at 1:00 p.m., the resident had been coughing and sneezing all day. She ate only a few bites of her food at lunch.

A physician order, dated 8/16/25, was for Paxlovid (medication used to treat COVID infections) x 5 days for COVID infection.

Documentation from 8/14/25 through 8/21/25 did not indicate Resident M had been placed in transmission based precautions and isolated to her room while symptomatic with COVID-19 respiratory symptoms.

On 8/28/25 at 2:38 P.M., the Administrator and Director of Nursing (DON) were interviewed. Both indicated the facility had no policy for isolation of residents with infectious disease which could be transmitted to other residents, staff, and visitors. The DON and Administrator indicated Resident M was dependent on staff and sat in a Broda chair. They

indicated staff took the resident to and from her room and dining room. They believed the resident had been kept in her room while having symptoms and feeling sick but had no documentation to provide indicating this.

A current facility policy, titled "Infection Control (General)", was provided by the Administrator on 8/28/25 at 10:00 A.M. The policy indicated "in all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection and are in compliance with the CDC guidelines. Employees are prohibited from working if suffering from a contagious illness while still in the infectious stage. Any Resident or Community personnel known to have a reportable disease as listed in the State or County Health Department regulations will be reported immediately to the local health district authority. The Community will comply with all infection control procedures as directed by the local health authority as a result of the reporting...." The Administrator, indicated the facility/company had no specific policies for identifying, managing, or caring for residents with suspected or confirmed COVID infections in the facility. The policy had not indicated when/if residents should be placed in isolation,

	infectious diseases isolation was required for or how long the isolation would last and the resident no longer able to transmit the infection to others. This Citation refers to Intake IN00464227.			

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 SIGNATURE	TITLE	(X6) DATE