STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/30/2026

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 the Investigation of Intake 467204. Intake 467204 - Deficiencies related to the allegations are cited at R0036 and R0240. Survey date: January 30, 2026 Facility number: 014576 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 3, 2026	R 0000	The Community acknowledges receipt of the findings related to the investigation of **Intake 467204**, with deficiencies cited under Tags **R0036** and **R0240** following the survey conducted on January 30, 2026.	
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:	R 0036	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents identified as having been affected by the deficient	02/05/2026

	(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure the physician and family were notified in a timely manner following a significant change in condition for 1 of 3 residents reviewed (Resident B). Findings include: A report, dated 1/9/26, alleged Resident B had gotten ill with recurrent vomiting/diarrhea and hadn't been eating or drinking. Neither the family nor the Nurse Practitioner (NP) had been notified until the resident required hospitalization for sepsis, dehydration, and acute kidney injury. On 1/30/26 at 10:39 a.m., Resident B's record was reviewed. Diagnoses included dementia and chronic obstructive pulmonary disease. A care plan, dated 10/23/25, indicated Resident B needed assistance with medication management. Staff were to		practice were **immediately accessed.** Appropriate **interventions were implemented without delay**, staff education specific to the residents' needs, physician, and responsible party notification 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. The community will have a **audit** of all residents to identify any others who may have the potential to be affected by this. This review will include medical records, care plans, staff documentation, and observation of care practices. What measures will be put into place or what systemic changes that the facility will make to ensure that the deficient practice does not recur. The Community will implement **education** to prevent recurrence, including revision and Education of policies and procedures to ensure compliance with regulatory requirements. All staff will receive **education** on any revised procedures. DON, ADON and ED will increase **oversight and accountability** through routine audits, and documentation review.	

	administer all her medications. An observation note, dated 12/12/25 at 1:45 p.m., indicated the resident appeared tired and worn out. An observation note, dated 12/20/25 at 8:15 p.m., indicated Resident B had been observed covered in vomit and bowel movement and required a shower. -At 8:30 p.m., the nurse indicated the resident threw up around 5:00 p.m. and had been vomiting since. Her vital signs were checked and normal and she had no fever. The observation note haven't indicated the family or NP/physician had been notified of Resident B's vomiting at 5:00 p.m. or her continued emesis. There were no observation notes written dated on or around 12/21/25. An NP note, dated 12/22/25 at 1:15 p.m., indicated Resident B was being seen for nausea, vomiting, and diarrhea. The resident indicated she'd had no nausea, vomiting or diarrhea. She indicated her appetite was poor but improving. The NP gave orders for Loperamide for diarrhea and Zofran for nausea/vomiting. Staff were to notify the NP of recurrent		**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** • Corrections will be monitored by DON and Ed. • DON will conduct **daily audits** for the first two weeks • . **Weekly audits** will then be completed for the next 60 days • **monthly audits** for compliance for 3 Months Changes will be completed by March 12th 2026	

	symptoms. Observation notes from 12/22/25-12/28/25 indicated the following: -12/23/25 at 8:45 p.m., Resident B refused her dinner meal but drank 120 milliliters (ml) of water. There were no observation notes for 12/24/25. On 12/25/25 at 1:15 p.m., Resident B refused breakfast and barely touched her lunch. She had been "aggravated" all day. -At 9:45 p.m., the resident refused to eat her dinner. On 12/26/25 at 10:00 p.m., Resident B refused her dinner. On 12/27/25 at 1:15 p.m., the resident was not feeling well, but had no vomiting or diarrhea. On 12/28/25 at 1:15 p.m., Resident B was still not feeling well. She hadn't eaten breakfast or lunch all weekend. A note was left for the NP to look at Resident B during her next visit. A NP note, dated 12/29/25 at 12:15 p.m., indicated Resident B was being seen for poor appetite and appearing unwell. Staff reported she was not eating or drinking much, was			

	lethargic and ill appearing. The resident's significant other was present, reported the resident was having difficulty swallowing and was more confused than usual. She was observed with a large mass of chewed up bread in her mouth she couldn't expel after several attempts. Her color was ashen with dark red circles beneath her eyes. Both lung bases had fluid in them, her fingers and extremities were cool to touch. She appeared very dry (not having had enough fluids) and had generalized weakness. She was cooperative with the exam but her confusion was worse than her baseline. The NP indicated the resident needed evaluation at the ER and the family was agreeable to. On 1/30/26 at 1:01 P.M., Resident B's family member was interviewed. They indicated the resident was transferred to the hospital on 12/29/25. She was diagnosed with sepsis, dehydration, and acute kidney injury. The family indicated they had not been notified Resident B was having vomiting, diarrhea, and not eating meals. The family member indicated Resident B moved into another facility following hospitalization and was fully recovered. On 1/30/26 at 1:33 P.M., the Director of Nursing (DON) was interviewed. She indicated when			

	a resident had a change in condition, such as recurrent vomiting, diarrhea, and decreased fluid intake, she, the Assistant Director of Nursing (ADON) or other nurse covering the facility were to be notified. Nurses were to assess the resident and notify the NP if needed. Qualified Medication Aids (QMA) who administered medications, were responsible to notify the nurse and the family with changes in condition. When asked, she indicated she had not known about the significant change in Resident B's condition until she was sent to the hospital on 12/29/25, but she should have been notified as well as the NP. A current copy of the facility policy, titled "Change of Condition" was provided by the Administrator on 1/30/26 at 3:10 P.M., which indicated changes in condition were when a resident experienced an alteration in their normal baseline evaluation. Changes could include altered mental status, or a physical, emotional or behavior change, and be a short term or long term change. When a resident had a change in condition, the DON or licensed nurse were to be notified and they would conduct an evaluation of the resident's condition. The DON or licensed nurse would notify the			

	physician/NP and note new orders. Family and/or Responsible party as well as the Administrator would be informed of the change in condition and new orders. The change in condition would be documented in the resident record and alert charting initiated for 72 hours or until the change in condition was resolved. This Citation relates to Intake 467204. Based on interview and record review, the facility failed to ensure the physician and family were notified in a timely manner following a significant change in condition for 1 of 3 residents reviewed (Resident B). Findings include: A report, dated 1/9/26, alleged Resident B had gotten ill with recurrent vomiting/diarrhea and hadn't been eating or drinking. Neither the family nor the Nurse Practitioner (NP) had been notified until the resident required hospitalization for sepsis, dehydration, and acute kidney injury. On 1/30/26 at 10:39 a.m., Resident B's record was reviewed. Diagnoses included dementia and chronic obstructive pulmonary disease. A care plan, dated 10/23/25,			

	indicated Resident B needed assistance with medication management. Staff were to administer all her medications. An observation note, dated 12/12/25 at 1:45 p.m., indicated the resident appeared tired and worn out. An observation note, dated 12/20/25 at 8:15 p.m., indicated Resident B had been observed covered in vomit and bowel movement and required a shower. -At 8:30 p.m., the nurse indicated the resident threw up around 5:00 p.m. and had been vomiting since. Her vital signs were checked and normal and she had no fever. The observation note haven't indicated the family or NP/physician had been notified of Resident B's vomiting at 5:00 p.m. or her continued emesis. There were no observation notes written dated on or around 12/21/25. An NP note, dated 12/22/25 at 1:15 p.m., indicated Resident B was being seen for nausea, vomiting, and diarrhea. The resident indicated she'd had no nausea, vomiting or diarrhea. She indicated her appetite was poor but improving. The NP gave orders for Loperamide for			

	diarrhea and Zofran for nausea/vomiting. Staff were to notify the NP of recurrent symptoms. Observation notes from 12/22/25-12/28/25 indicated the following: -12/23/25 at 8:45 p.m., Resident B refused her dinner meal but drank 120 milliliters (ml) of water. There were no observation notes for 12/24/25. On 12/25/25 at 1:15 p.m., Resident B refused breakfast and barely touched her lunch. She had been "aggravated" all day. -At 9:45 p.m., the resident refused to eat her dinner. On 12/26/25 at 10:00 p.m., Resident B refused her dinner. On 12/27/25 at 1:15 p.m., the resident was not feeling well, but had no vomiting or diarrhea. On 12/28/25 at 1:15 p.m., Resident B was still not feeling well. She hadn't eaten breakfast or lunch all weekend. A note was left for the NP to look at Resident B during her next visit. A NP note, dated 12/29/25 at 12:15 p.m., indicated Resident B was being seen for poor			

	appetite and appearing unwell. Staff reported she was not eating or drinking much, was lethargic and ill appearing. The resident's significant other was present, reported the resident was having difficulty swallowing and was more confused than usual. She was observed with a large mass of chewed up bread in her mouth she couldn't expel after several attempts. Her color was ashen with dark red circles beneath her eyes. Both lung bases had fluid in them, her fingers and extremities were cool to touch. She appeared very dry (not having had enough fluids) and had generalized weakness. She was cooperative with the exam but her confusion was worse than her baseline. The NP indicated the resident needed evaluation at the ER and the family was agreeable to. On 1/30/26 at 1:01 P.M., Resident B's family member was interviewed. They indicated the resident was transferred to the hospital on 12/29/25. She was diagnosed with sepsis, dehydration, and acute kidney injury. The family indicated they had not been notified Resident B was having vomiting, diarrhea, and not eating meals. The family member indicated Resident B moved into another facility following hospitalization and was fully recovered.			

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	an evaluation of the resident's condition. The DON or licensed nurse would notify the physician/NP and note new orders. Family and/or Responsible party as well as the Administrator would be informed of the change in condition and new orders. The change in condition would be documented in the resident record and alert charting initiated for 72 hours or until the change in condition was resolved. This Citation relates to Intake 467204.			
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 as planned for 2 of 3 residents reviewed (Resident C and Resident D). Findings include: 1. On 1/30/26 at 2:25 P.M., Resident C's record was reviewed. Diagnoses included Alzheimer's disease and seizures.	R 0240	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. This RULE is not met as evidenced by: R 240 Based on interview and record review, the facility failed to ensure care was provided as planned for 2 of 3 residents reviewed (Resident C and Resident D). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • Residents affected by the	02/05/2026

A care plan, dated 1/30/26, indicated Resident C needed his medications managed and administered by a nurse or Qualified Medication Aid (QMA). A nurse or QMA were to administer and oversee his medication needs.

A physician order, dated 1/13/25, was for Cyanocobalam (Vitamin B12) injection 1000 micrograms (mcg)-inject 1 milliliter (ml) intramuscularly every month.

A Medication Administration Record (MAR), dated November 2025, indicated Cyanocobalam injection had been scheduled to be given on 11/1/25. The medication was not administered due to no nurse being in the facility. The MAR hadn't indicated the injection had been given on any day in November.

An MAR, dated January 2026, indicated Cyanocobalam injection had been scheduled to be given on 1/1/26. The medication was not administered due to no nurse being in the facility. The MAR hadn't indicated the injection had been given on any day in January.

2. On 1/30/26 at 2:39 P.M., Resident D's record was reviewed. Diagnoses included Parkinson's disease and

deficient practice were **assessed** by licensed nursing staff. Their **individualized care plans were reviewed and updated** to accurately reflect personal care and ADL needs and preferences. Direct care staff were **re-educated** on the residents' specific care plan requirements.

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.

- The community will conduct a **review** of all residents' care plans, and documentation to identify any other residents who may have the potential to be affected by the same deficient practice.

What measures will be put into place or what systemic changes will the community make to ensure that the deficient practice does not recur.

The community will implement **systemic measures** to ensure personal care and assistance with activities of daily living are provided according to each

	osteoporosis. A care plan, dated 1/30/26, indicated Resident D needed assistance with all aspects of her medication management. Staff were to provide her with all her daily medications. A physician order, dated 10/1/25, was for Ibandronate (used to treat osteoporosis) 150 milligram tablets-1 tablet by mouth every month. An MAR, dated October 2025, indicated the medication was scheduled to be given on 10/1/25 but had not been administered due to not being reordered from the pharmacy. There was no documentation on the October MAR to indicate the medication had been administered after it was re-ordered and received from the pharmacy. An MAR, dated January 2026, indicated the medication was scheduled to be given on 1/1/26 but had not been administered due to not being reordered from the pharmacy. A grievance, dated 1/5/26, made by Resident D, indicated each month, the resident would ask her nurse if the Ibandronate was signed out and re-ordered for the next month. She indicated in the past, it had been given late or not at all. She		resident's individual needs and preferences. All direct care staff will receive **education on current** care plans and honoring resident preferences. DON will oversee and educate with any noncompliance. **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.** Daily **audits** will be conducted for the first two weeks by DON and ADON Weekly **audits** will be completed by DON and ADON for 2 months as part of ongoing Monitoring to sustain compliance. Monthly audits will be 4 months after this by DON and ADON. All systemic changes, including **policy and procedure updates, staff re-education, competency validation, and implementation of monitoring processes,** will be **completed by March 12 th 2026.** Ongoing audits and monitoring will continue beyond this date to ensure sustained compliance.	

asked if some protocol could be put in place so she would receive the medication monthly as ordered. On 1/6/26, the Administrator indicated the DON was notified of the grievance and was to follow up with the resident.

There was no documentation on the January MAR to indicate the medication had been administered after it was re-ordered and received from the pharmacy. The medication was not given as ordered in January 2026 despite Resident D voicing her concerns and filing a grievance.

On 1/30/26 at 1:17 P.M., Qualified Medication Aid (QMA) 2 was interviewed. She indicated medications were to be given as ordered and documented on the MAR. QMA 2 indicated when the MAR was not initialed, it would mean the medication was not given.

On 1/30/26 at 3:10 P.M., the Administrator was interviewed. She indicated medications were to be given as ordered by the physician and/or Nurse Practitioner.

A current facility policy, titled "Medication Administration" indicated medications would be administered per physician orders. The community was to ensure residents were given the

correct medications at the right time, in the right dosage per physician orders, and per state regulations.

This Citation refers to Intake 467204.

Based on interview and record review, the facility failed to ensure care was provided as planned for 2 of 3 residents reviewed (Resident C and Resident D).

Findings include:

1. On 1/30/26 at 2:25 P.M., Resident C's record was reviewed. Diagnoses included Alzheimer's disease and seizures.

A care plan, dated 1/30/26, indicated Resident C needed his medications managed and administered by a nurse or Qualified Medication Aid (QMA). A nurse or QMA were to administer and oversee his medication needs.

A physician order, dated 1/13/25, was for Cyanocobalam (Vitamin B12) injection 1000 micrograms (mcg)-inject 1 milliliter (ml) intramuscularly every month.

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be given on 11/1/25. The medication was not administered due to no nurse being in the facility. The MAR hadn't indicated the injection had been given on any day in November.

An MAR, dated January 2026, indicated Cyanocobalam injection had been scheduled to be given on 1/1/26. The medication was not administered due to no nurse being in the facility. The MAR hadn't indicated the injection had been given on any day in January.

2. On 1/30/26 at 2:39 P.M., Resident D's record was reviewed. Diagnoses included Parkinson's disease and osteoporosis.

A care plan, dated 1/30/26, indicated Resident D needed assistance with all aspects of her medication management. Staff were to provide her with all her daily medications.

A physician order, dated 10/1/25, was for Ibandronate (used to treat osteoporosis) 150 milligram tablets-1 tablet by mouth every month.

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reordered from the pharmacy. There was no documentation on the October MAR to indicate the medication had been administered after it was re-ordered and received from the pharmacy.

An MAR, dated January 2026, indicated the medication was scheduled to be given on 1/1/26 but had not been administered due to not being reordered from the pharmacy.

A grievance, dated 1/5/26, made by Resident D, indicated each month, the resident would ask her nurse if the Ibandronate was signed out and re-ordered for the next month. She indicated in the past, it had been given late or not at all. She asked if some protocol could be put in place so she would receive the medication monthly as ordered. On 1/6/26, the Administrator indicated the DON was notified of the grievance and was to follow up with the resident.

There was no documentation on the January MAR to indicate the medication had been administered after it was re-ordered and received from the pharmacy. The medication was not given as ordered in January 2026 despite Resident D voicing her concerns and filing a grievance.

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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) DATE02/16/2026