STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155656	A. BUILDING <u>00</u> B. WING		00	COMPLETED 12/12/2022		
100000			D. WI	_		12/12/	2022	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
CANTERBURY NURSING AND REHABILITATION CENTER				FORT WAYNE, IN 46835				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	COMPLETION DATE	
F 0000	REGUENTURY UN	REGULATORY OR LSC IDENTIFYING INFORMATION		1110			5.112	
Bldg. 00	This visit was for the Investigation of Complaint		F 0000		This facility is requesting pape	ar		
		visit was in conjunction with a	F 0000		compliance. Thank you	ē1		
		State Licensure Survey						
	Complaint IN00396	5293 - Substantiated.						
	Federal/state deficie	encies related to the						
	allegations are cited	l at F 791						
	Survey dates: December 6, 7, 8, 9, and 12, 2022							
	Facility number: 000275							
	Provider number: 155656							
	AIM number: 100290930							
	Census Bed Type:							
	SNF/NF: 90							
	Total: 90							
	Census Payor Type: Medicare: 2							
	Medicaid: 76 Other: 12							
	Other: 12 Total: 90							
	-	ects State Findings cited in						
	accordance with 410 IAC 16.2-3.1.							
	Quality review com	pleted December 13, 2022						
F 0791 SS=D Bldg. 00	§483.55 Dental Se The facility must a	cy Dental Srvcs in NFs ervices ssist residents in obtaining ur emergency dental care.						
	§483.55(b) Nursing The facility-	g Facilities.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Meeta Anand Executive Director 12/22/2022

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2EK011 Facility ID: 000275 If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155656	A. BUILDING <u>00</u> B. WING		COMPLETED 12/12/2022		
133030						12/12/	2022
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD ORTHGATE BLVD		
CANTERBURY NURSING AND REHABILITATION CENTER			_		VAYNE, IN 46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG	§483.55(b)(1) Mustoutside resource, §483.70(g) of this services to meet the (ii) Routine dental covered under the (iii) Emergency derivatives (iii) Emergency derivatives (iv) In making appote (iv) By arranging for the dental services within 3 days, the documentation of resident could still while awaiting derextenuating circum delay; §483.55(b)(4) Mustone circumstance damage of dentures responsibility and for the loss or dand determined in acce to be the facility's	est, if necessary or if the resident- continuents; and or transportation to and from a locations; est promptly, within 3 days, the lost or damaged dentures are lead to the leat and drink adequately that services and the metances that led to the leat and drink adequately that services and the metances that led to the leat and drink adequately that services and the metances that led to the leat and drink adequately that services and the metances that led to the leat and drink adequately that services and the metances that led to the leat and or identifying the services are sident and policy identifying the services or dentures or dentu		TAG			DATE
	eligible and wish t reimbursement of	st assist residents who are to participate to apply for dental services as an expense under the State					04.007.5555
	Based on observation	on, interview, and record	F 07	/91	F 791 Based on observation,		01/06/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2EK011

Facility ID: 000275

If continuation sheet Page 2 of 5

AND PLAN OF CORRECTION ISSOCIATION SUMMER ISSOCIATION SUMMER INVINO INVINO	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/12/2022 155656 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2827 NORTHGATE BLVD CANTERBURY NURSING AND REHABILITATION CENTER FORT WAYNE. IN 46835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE department head follow-up note dated 10/27/22, changes will be made to indicated the dentures were located the following ensure that the deficient day and staff offered to lock them in the nurse's practice does not recur cart. Resident B declined the offer and the IDT re-education on the dentures were missing again. Section III of the Oral Status and Swallowing grievance form, follow up communication with the Disorder Screening form in Matrix individual filing the report, dated 10/4/22, and Dental Services / Missing indicated the Social Enrichment Director called the Dentures Policy will be completed Resident B's son, explained the resident refused to by Jan 6, 2023 have her dentures locked up and they were lost IDT will identify any resident again. An additional note in this section, also with an identified need for dental dated 10/4/22 indicated there were no further services. The identified resident issues. No explanation of date discrepancies was will have a dental referral received by the time of exit. Additional notes completed as indicated. IDT will attached to the grievance form indicated the follow up to ensure that the dental subject was reviewed on 11/18/22 during a care referral was made and completed plan meeting. Additional notes indicated dental by 01/06/2023 by Social Services offices were contacted regarding quotes for Director or designee. denture replacement on 11/21/22, 11/28/22, and IDT re-education regarding 12/2/22. the Resident Concerns and Grievance Policy will be Documents titled Oral Status and Swallowing completed Disorder Screening forms dated 11/14/22 and 11/22/22 were reviewed. The checklist style form How the corrective action(s)will had no check marks, notes, or any other indication be monitored to ensure the a screening had been completed. No signature or deficient practice will not date was on either form to indicate completion. recur, i.e; what quality assurance program will be put During an interview on 12/8/22 at 10:50 AM, the into place. Director of Nursing indicated she did not know The Dental Services QAPI why the Oral Status and Swallowing Disorder tool will be completed by the screening forms were not completed. Social Services Director or Designee weekly x 4 weeks, and A care plan dated 10/5/21 indicated Resident B monthly for 6 months and then had dentures, she should have had a dental every quarter as indicated by the consult as indicated and should have been Social Services QAPI Calendar. observed for decreased ability to chew food. This will be presented and reviewed by the Interdisciplinary A current policy titled Resident Concerns and Team at the QAPI meeting each

Grievances, last revised 1/19, indicated actions

month.

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

PRINTED: 01/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155656	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2022		
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2827 NORTHGATE BLVD FORT WAYNE, IN 46835				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	should be taken to resolve the complaint within 72 hours of the time the concern was received. No records regarding oral screening to determine ability to effectively chew without the missing dentures were available for review at the time of exit. No records regarding contact with a dental office about missing dentures prior to 11/21/22 were available for review at the time of exit. This Federal tag relates to complaint IN00396293. 3.1-24(a)(3)				By what date the systemic changes for each deficiency will be completed. The systemic changes will be completed by January 06 2023		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2EK011 Facility ID: 000275 If continuation sheet Page 5 of 5