	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted '2024
	PROVIDER OR SUPPLIER			9210 M	ADDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD NAYNE, IN 46815		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 00							
Blug. 00	Survey. This visit i Complaint IN00431	428 - State deficiencies related	R 0	000	see attached.		
	-	1 30, May 1 and 2, 2024.					
	Facility number: 01	4576					
	Census: 66						
	These State Resider accordance with 410	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review com	pleted May 6, 2024					
R 0044	410 IAC 16.2-5-1.	, , , ,					
Bldg. 00	residents of a facil (1) As used in this transfer and disch movement of a res the licensed facilit (2) As used in this transfer " means to a bed within the (3) When a transfe is proposed, whetl interfacility, provis shall be provided I (4) Health facilities to remain in the fa	d discharge rights of lity are as follows: section, " interfacility arge " means the sident to a bed outside of y. section, " intrafacility the movement of a resident e same licensed facility. er or discharge of a resident ther intrafacility or ion for continuity of care					

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

TITLE (X6) DATE

Victoria Winchell Regional Director of Nursing 07/22/2024

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 disclo days 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.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED	
			B. W	ING		05/02	/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			IAYSVILLE ROAD			
CEDABL	HURST OF FORT V	VAVNE			WAYNE, IN 46815			
CEDANI	IUNGT OF FUNT V	VATNE		FORT	WATNE, IN 40015			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(A) the transfer or	discharge is necessary for						
	the resident 's we	elfare and the resident ' s						
	needs cannot be met in the facility;							
	(B) the transfer or	discharge is appropriate						
	because the resid	lent ' s health has improved						
	sufficiently so that	t the resident no longer						
	needs the service	es provided by the facility;						
	(C) the safety of i	ndividuals in the facility is						
	endangered;							
	(D) the health of individuals in the facility would otherwise be endangered;(E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or							
	(F) the facility cea							
		lity proposes to transfer or						
	_	ent under any of the						
	-	ecified in subdivision (4)(A),						
		(D), or (4)(E), the resident 's						
		ust be documented. The						
		ust be made by the						
	following:							
		s physician when transfer						
	_	ecessary under subdivision						
	(4)(A) or (4)(B).							
	1 ' ' ' ' '	when transfer or discharge						
		er subdivision (4)(D).	_				44/85/55	
		and record review, the facility	R 0	044	Please indicate what actions		11/30/2024	
		nsfer documentation was			the facility had taken to ensu	ire		
	_	residents reviewed (Resident			residents affected were			
	8).				addressed Please indicate th			
	F' 1' ' 1 1				actions the facility has taken			
	Findings include:				ensure no other residents we	ere		
	D:4 (0)				affected by the alleged			
	_	was reviewed on 5/1/24 at 9:20			deficient practice.			
	AM. Diagnoses included bipolar disorder and major depressive disorder with psychotic symptoms.				Please indicate who is			
					responsible, the duration and	a		
					frequency of monitoring to			
		111/12/24 110 20 135			prevent recurrence.			
	A progress note dat	ted 11/13/24 at 10:30 AM			DON or designee will review			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/02/2024	
	PROVIDER OR SUPPLIEF			9210 M	ADDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD VAYNE, IN 46815		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	indicated Resident A progress note dat indicated Resident 11/20/23 due to the Resident 8 had no progress note dat indicated to the hosy to the responsible progress note dat indicated charting or being readmitted. To indicate date and time A progress note dat indicated charting or being readmitted. To indicate date and time A progress note dat indicated charting or being readmitted. To indicate date and time A progress note dat indicated charting or being readmitted. To indicate date and time A progress note data indicated charting or being readmitted. To indicate date and time A progress note data indicated Resident and did not engage had been resistant to been eating, drinking Resident 8's apartment they had not been less indicated to the progress of the progress of the progress in the	8 had refused breakfast. sed 11/21/23 at 3:45 PM 8 did not see the podiatrist on resident being in the hospital. progress notes dated 11/14/23 of indicate the resident had been pital, why or any notifications party. sed 11/29/23 at 10:00 PM continued due to Resident 8 of readmission. sed 11/30/23 at 1:15 PM continued due to Resident 8 of readmission. sed 11/30/23 at 9:45 PM continued due to Resident 8 of readmission. sed 11/30/23 at 9:45 PM continued due to Resident 8 of readmission. sed 11/30/24 at 11:30 AM 8 had a flat facial expression in conversation. Resident 8 of care. Resident 8 had not ang, or sleeping well. sent was soiled with waste as setting the dog out. Resident		TAG	documentation daily x 2 weeks 2x week x4, then weekly x4 weeks. Please explain the role the facility quality assurance program will have in the on-going monitoring process ensure this deficiency does recur. How often will the Quality Assurance program review monitoring and for when the program review monitoring and for when the property of time? DON is responsible for sustained compliance. Monitoring will be going for 3 months. The Quality Assurance Team will review draw ROAR monthly to determine if continued auditing is necessare based on 3 consecutive month compliance.	on- ty uring	DATE
	A progress note dat indicated Resident refused care. Reside	rey (POA) was updated on the red 1/16/24 at 11:15 AM 8 refused to get out of bed and ent 8 was transferred to the ulance due to continuing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURV COMPLETED 05/02/2024)	
	ROVIDER OR SUPPLIER JRST OF FORT W		9210 M	ADDRESS, CITY, STATE, ZIP COD IAYSVILLE ROAD WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE CO	(X5) MPLETION DATE
	Resident 8 had beer Resident 8 had no p through 3/4/24. In an interview on 5 Nurse Specialist inc transfer forms wher the hospital. The Re indicated transfer de resident condition, t date, the time, and t facility. In an interview on 5 Nurse Specialist inc	ed 3/5/24 at 3:24 PM indicated in discharged to hospice care. Progress notes dated 1/17/24 5/2/24 at 12:10 PM the Regional dicated the facility did not use in residents were transferred to begional Nurse Specialist ocumentation should include the reason for the transfer, the he location of the receiving 5/2/24 at 2:25 PM the Regional dicated hospital transfer cumented in a Resident Status				
	Specialist provided Log. The status log indite emergency room at 7:29 PM. The status log indicadmitted to the hosp. The status log indicemergency room on The status log indicto the hospital on 1/2. The status log indiction to the hospital on 1/2. The status log indiction the status log indiction to the hospital on 1/2. The status log indiction to the status log indiction to the hospital on 1/2. The status log indiction to the status log indicti	cated Resident 8 was cacility and moved to hospice				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILI	DING	NSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED
			B. WING			05/02/2024
	PROVIDER OR SUPPLIEF		g	210 M	.DDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD VAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
R 0052		licated the facility did not have documentation or		AG		DATE
Bldg. 00	Residents' Rights - Offense g. 00 (v) Residents have the right to be free from:					
	(1) sexual abuse;(2) physical abuse;(3) mental abuse;(4) corporal punis(5) neglect; and(6) involuntary sea	hment;				
	Based on interview failed to ensure pro	and record review the facility tection from physical abuse ation for 1 of 5 reviewed	R 0052	2	Please indicate what actions the facility had taken to ensuresidents affected were addressed. /p>	117007202.
	Findings include:				Please indicate the actions the facility has taken to ensure n	
	During an interview on 4/30/24 at 2:40 PM, the Operations Specialist indicated she was in the process of investigating an abuse allegation and was preparing to report it to the state office. A report of the allegation provided by the Operations Specialist on 5/1/24 at 9:10 AM indicated Resident 5 had entered a female resident's room and urinated on the floor. The female resident's husband allegedly made contact with Resident 5. Resident 5's record was reviewed on 5/1/24 at 10:16 AM. Diagnoses included acute diastolic (congestive) heart failure, aphasia, dementia in other diseases classified elsewhere, moderate, with agitation.				other residents were affected by the alleged deficient practice. The Executive Direct (ED) and Director of Nursing (DON) completed re-education 5/15/2024 regarding Cedarhur communication expectation pound procedures and Indiana Scapeartment of Health long termicare abuse and incident report policy to include any event or suspected event that occurs in community will be reported to ED and DON immediately so a investigation can be completed per Cedarhurst policy and Statiregulations. Please indicate who is	tor n on est clicy state m ting n the the an d as te
		ement dated 4/30/24 provided specialist on 5/1/24 at 10:38			responsible, the duration and frequency of monitoring to	d

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/02/2024	
	PROVIDER OR SUPPLIER		9210 M	ADDRESS, CITY, STATE, ZIP COD IAYSVILLE ROAD WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	AM, on 4/28/24 at a Aid (CNA) 4 indica 5 out of a female rewandered into where in a chair. She indicated a resident resident resident resident resident resident resident and pushed. In an undated employment of the Operations Special of the resident's husbart the resident's husbart the resident's husbart the room. She did not resident 5 wasn't has 5 regularly wandered. The statement did not action to escort the abused Resident 5 from Resident 6 from Resident	about 6:00 PM, Certified Nurse ted she was assisting Resident sident's bathroom he had he became combative and sat cated the husband of the the room hit Resident 5 on the d him as he exited the room. An open statement provided by sialist on 5/1/24 at 10:38 AM, Aide (QMA) 5 indicated she asband yelling "get out, get had wandered into his wife's ted on the floor. She indicated and escorted Resident 5 out of not report the incident because farmed. She indicated Resident d into rooms and urinated. Out include any immediate family member alleged to have from the unit to maintain sident 5. The mement dated 4/30/24, provided pecialist on 5/1/24 at 1 Medicine Aide (QMA) 6 mber told her she had reported se to the QMA on the prior he did not take any action or indicated she reported what she dent Care Manager (RCM) on DPM. QMA 6 also indicated mation in shift change to		prevent recurrence. The Executive Director and D are responsible for sustained compliance. Please explain the role the fact quality assurance program with have in the on-going monitoring process to ensure this deficient does not recur. How often will Quality Assurance program remonitoring and for what length time? Residents will be discuss at the weekly ROAR meeting. will help with early identification residents at risk and trigger the necessary follow-up measures which could include meetings families, notifications to physicians, investigations, and incident reporting if warranted. This meeting will be held ween by the Executive Director/designee and DON/designee. The Executive Director and Business Office Manager will audit all new hire orientations weekly to ensure training on reportable events a completed. Monitoring will be ongoing.	ON cility II ng ncy the eview n of esed This on of e s with d . kly

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	OF CORRECTION IDENTIFICATION NUMBER A. I			ULTIPLE CO JILDING NG	nstruction <u>00</u>	(X3) DATE : COMPL 05/02/	ETED
	PROVIDER OR SUPPLIER			9210 M	DDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD VAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	statement from him inability to visit on was completed. She involved in the alleg allowed to visit the resided if she had be immediately per produced in the property of the complete that it is a current policy title Exploitation Prevent Investigation Policy 3/14/22, provided be Operations indicated	ed Abuse, Neglect, and tion, Prohibition, and and Procedures, dated the Regional Director of dupon an abuse allegation,					
		abusing the resident should ne resident immediately.					
R 0090	410 IAC 16.2-5-1. Administration and	3(g)(1-6) d Management - Deficiency					
Bldg. 00	(g) The administrative overall management responsibilities of include, but are not (1) Informing the cocurrence that discussed in the cocurrence that discussed in the cocurrence telephone, follower a written report on electronic mail to the twenty-four (24) hos occurrences include (A) epidemic outbin (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence include (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence (B) poisonings; (C) fires; or (D) major accidentifications of the cocurrence (B) poisoning	ator is responsible for the cent of the facility. The the administrator shall of limited to, the following: division within twenty-four oming aware of an unusual rectly threatens the health of a resident. Notice cence may be made by d by a written report, or by ly that is faxed or sent by the division within the cour time period. Unusual de, but are not limited to: reaks;					

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	AN OF CORRECTION IDENTIFICATION NUMBER A. BUIL		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/02/2024
	PROVIDER OR SUPPLIER		9210 M	ADDRESS, CITY, STATE, ZIP COD IAYSVILLE ROAD WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the provision of m nursing care or oth requested by the representative. (3) Obtaining direct admission of an in years of age to an (4) Ensuring the fapremises, an acculoworked that indicated (A) employee's full (B) dates and hou twelve (12) month (5) Posting the resumment of the state surveyors, a effect with respect subsequent surve available for examplace readily accentice posted of the (6) Maintaining reply the division in examplating the state of the control of	acility maintains, on the urate record of actual time attes the: I name; and rs worked during the past s. sults of the most recent the facility conducted by any plan of correction in a to the facility, and any any sys. The results must be an ination in the facility in a assible to residents and a aneir availability. Poorts of surveys conducted each facility for a period of making the reports action to any member of the	R 0090	Please indicate what actions	05/24/2024
		allegation of abuse was manner for 1 of 3 residents 5).		the facility had taken to ensu residents affected were addressed Please indicate the actions the facility has taken	ire ne
	Operations Speciali was an allegation of process of investiga	or on 4/30/24 at 2:40 PM, the st indicated, on 4/28/24, there f abuse. She was in the ting the abuse allegation and port it to the state office.		ensure no other residents we affected by the alleged deficient practice. Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence. The Executive Director and Definition of the state of	d

State Form Event ID: 3RN111 Facility ID: 014576 If continuation sheet Page 8 of 34

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. W	ING		05/02/	2024
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
					AYSVILLE ROAD		
CEDARH	IURST OF FORT W	VAYNE		FORT V	VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		gation provided by the			are responsible for sustained		
	Operations Specialist on 5/1/24 at 9:10 AM				compliance.		
	indicated on 4/28/24 at about 6:00 PM, Resident 5				compilance.		
		le resident's room and urinated			Please explain the role the		
		male resident's husband			="		
		tact with Resident 5.			facility quality assurance		
	anegedry made con	tact with Resident 3.			program will have in the	de la	
	Dagidant 51= 1	was raviowed an 5/1/04 -4			on-going process to ensure t		
		was reviewed on 5/1/24 at			deficiency does not recur. Ho	w	
	_	ses included acute diastolic			often will the Quality		
		ailure, aphasia, dementia in			Assurance program review	41-	
		ified elsewhere, moderate,			monitoring and for what leng		
	with agitation.				of time? The Executive Direct	or is	
					responsible for sustained		
	In an employee statement dated 4/30/24 provided				compliance. Residents will be		
		Specialist on 5/1/24 at 10:38			discussed at the weekly ROAF		
		se Aid (CNA)4 indicated she			meeting. This will help with ea	-	
	_	ent 5 out of a female resident's			identification of residents at ris	k	
		andered into when he became			and trigger the necessary		
		n a chair. She indicated the			follow-up measures which cou		
		dent residing in the room hit			include meetings with families		
		houlder and pushed him as he			notifications to physicians,		
	exited the room.				investigations, and incident		
					reporting if warranted. This		
	In an employee stat	ement dated 4/30/24 provided			meeting will be held weekly by	the	
		Specialist on 5/1/24 at			Executive Director/designee a	nd	
	10:38AM, Qualified	d Medicine Aide (QMA) 6			DON/designee. The Executive	9	
	indicated a staff me	ember told her she had reported			Director and Business Office		
	an allegation of abu	se to the QMA on the prior			Manager will audit all new hire		
	shift and she did no	t take any action or report it.			orientations weekly to ensure		
	QMA 6 indicated sl	he reported what she was told			training on reportable events is	3	
	to the Resident Care	e Manager (RCM) on 4/28/24			completed. Monitoring will be		
	around 8:00 PM. Q	MA 6 also indicated she			ongoing.		
	passed the informat	tion in shift change report to					
	QMA 3 on the morn						
		-					
	In an employee stat	ement dated 4/30/24 provided					
		Specialist on 5/1/24 at 10:38					
		cated QMA 6 reported to her					
		ation was reported to her. No					
	_	any other member of the					
		,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	COM	e survey pleted 12/2024	
	PROVIDER OR SUPPLIE		9210 M	ADDRESS, CITY, STATE, ZIP C AYSVILLE ROAD WAYNE, IN 46815	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION was addressed in the statement.	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	In an interview on a Operations Special of the incident on 4 indicated staff shou and then immediate abuse to the Director Administrator. The Administrator shou Support staff immediate and the interview on a Regional Director of management team of the morning meeting member assigned to A current policy to Exploitation Prever Investigation Policy 3/14/22, provided to Operations indicate intentionally or rector cause harm to a reconstitutes abuse.	5/1/24 at 10:38 AM, the ist indicated she was notified b/29/24, but did not report the he IDOH channels. She ald ensure the resident's safety ely report any allegations of or of Nursing and Director of Nursing and ald then notify Corporate				
R 0117 Bldg. 00	qualifications, and applicable state la twenty-four (24) h unscheduled need services provided and training of sta	• •				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	ETED
			B. WING			05/02/	/2024
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>			DDRESS, CITY, STATE, ZIP COD		
					AYSVILLE ROAD		
CEDARF	IURST OF FORT W	VAYNE	F	ORT V	VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		ninimum of one (1) awake					
		current CPR and first aid					
	certificates, shall be on site at all times. If						
		residents of the facility					
		residential nursing services					
		of medication, or both, at					
	, ,	ing staff person shall be on					
		esidential facilities with					
		(100) residents regularly					
	_	ial nursing services or					
	administration of medication, or both, shall have at least one (1) additional nursing staff						
		-					
		d on duty at all times for fty (50) residents. Personnel					
	1	only those duties for which					
		p perform. Employee duties					
		n written job descriptions.					
		and record review the facility	R 0117	,	- Please indicate what actions the facility had taken to ensure residents affected were		11/30/2024
		irst Aid and cardiopulmonary	K UI1/				11/30/2024
		certified staff member was					
	, ,	for 5 of 7 days reviewed.					
]	. J			addressed Please indicate th	ie	
	Findings include:				actions the facility has taken		
					ensure no other residents we		
	A review of the pro	evious 7-day schedule of actual			affected by the alleged		
	_	1 4/25/24 through 5/1/24			deficient practice. Audit of all		
	indicated there was	not a First Aid and CPR			active employee files to deterr		
	certified staff meml	ber on duty for the following			compliance with CPR		
	dates and times: 4/2	25/24- second shift, 4/26/24-			requirements. Employees four	nd	
	second shift, 4/27/2	4- third shift, 4/29/24- second			out of compliance have been		
	shift and 4/30/24- s	econd shift.			instructed to complete CPR or		
					they will be removed from the		
		5/2/24 at 1:25 PM the Regional			schedule until it is completed.		
		ist indicated they were unaware			Please indicate who is		
	of a regulation regarding a CPR and First Aid certified staff member not on duty at all times. The Regional Operations Specialist indicated the				responsible, the duration and	d	
					frequency of monitoring to		
					prevent recurrence.		
		ys have a staff member with			The Executive Director/ BOM	is	
		certification on duty. The			responsible for sustained		
1	I Regional Operation	s Specialist indicated the			compliance		I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/02/2024	
	PROVIDER OR SUPPLIER		9210 M	ADDRESS, CITY, STATE, ZIP COD IAYSVILLE ROAD WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	facility did not have First Aid certification	a policy related to CPR and on.		Please explain the role the facility quality assurance program will have in the on-going monitoring process ensure this deficiency does recur. How often will the Quality Assurance program review monitoring and for will length of time? The Executiv Director and Business Office Manager will audit all new hire weekly. Monitoring will be ongoing. Percentage goal for compliance is 100%.	not hat e	
R 0216 Bldg. 00	shall be delineated manual, but at a massessment shall following: (1) The resident 's mental status. (2) The resident 's activities of daily li (3) The resident 's admission and ser (4) If applicable, the self-administer me	content of the evaluation d in the facility policy ninimum the needs include an evaluation of the sphysical, cognitive, and sindependence in the ving. It is weight taken on miannually thereafter. The resident's ability to edications.				
	failed to ensure sem completed for 2 of 5 and Resident 4). Findings include:	and record review the facility i-annual evaluations were residents reviewed (Resident ord was reviewed on 5/1/24 at	R 0216	Please indicate what actions the facility had taken to ensuresidents affected were addressed. DON/designee with complete assessments weekly ensure assessments are updated and on time until 100 compliants is reached. Self-Administered	ill y to ated	

State Form Event ID: 3RN111 Facility ID: 014576 If continuation sheet Page 12 of 34

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 05/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9210 MAYSVILLE ROAD CEDARHURST OF FORT WAYNE FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 10:16 AM. Diagnoses included acute diastolic Medication Assessment forms (congestive) heart failure, aphasia, dementia in completed by 7/31/24 on all other diseases classified elsewhere, moderate, residents who self-administer with agitation. medications. Please indicate the actions the A document titled Move-in/6 Month Assessment facility has taken to ensure no dated 2/13/24 included assessments for fall risk. other residents were affected elopement risk, skin breakdown risk, and memory by the alleged deficient testing. The document did not include any practice. DON re-educated on responses in any of the assessment areas. Cedarhurst assessment policy and procedures. In an interview on 5/2/24 at 9:40 AM, the Regional Please indicate who is Nurse Specialist indicated the assessment areas responsible, the duration and were not completed.2) In an interview on 4/30/24 frequency of monitoring to at 2:10 PM, Resident 4 indicated he administers prevent recurrence. his own medication. He indicated his medications DON is responsible for monitoring. were in a medication box filled by his daughter Please explain the role the once a week. He indicated the medication box facility quality assurance dispensed his medication for him. program will have in the on-going monitoring process to During an observation on 4/30/24 at 2:10 PM, ensure this deficiency does not Resident 4 pointed to a black metal medication box recur. How often will the approximately 14 inches by 14 inches sitting on Quality Assurance program top of his kitchen counter. he indicated the box review monitoring and for what was an automatic medication dispenser. length of time? DON or designee will continue to perform Resident 4's record was reviewed on 5/1/24 at 1:43 reassessments as needed for an PM. Diagnoses included dementia, diabetes ongoing duration. Residents will mellitus, primary hypertension, generalized muscle be discussed at the weekly ROAR weakness, abnormal gait and mobility, unsteady meeting. This will help with early on feet, and traumatic subdural hemorrhage with identification of residents at risk loss of consciousness. and trigger the necessary follow-up measures which could Resident 4's current initial Individual Service Plan include meetings with families, (ISP), dated 2/14/24, Medical Management task notifications to physicians, box was checked and indicated it was a investigations, and incident non-scheduled item. The Medical Management reporting if warranted. This task indicated the resident needed someone to meeting will be held weekly by the assist with all aspects of medication management Executive Director/designee and on a daily basis with the provider of the service as DON/designee.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/02/2024		
	PROVIDER OR SUPPLIER		9210 M	ADDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	1/29/24 was completed initial Assessment in risk, elopement risk MMSE (Mini Mentaguestion assessment evaluates attention are gistration, recall, ability to draw a conself-Administration Resident 4's Initial except his Self-Admassessment. The remedication assessment through 17 were not Self-Administration results were not confused assessment LOC (I indicated he was incompared to the medication should be all residents at least indicated Resident amedication. The Remedication in the Remedication of 6 months. A current policy titl Administration Policy provided by the Remedicated by the Remedicated resident and the remedication of the remedication of the remedication of the remedication of the remedication policy titl Administration Policy titl Poli	Initial Assessment" dated sted by LPN 10. Resident 4's included assessments for: fall factors, skin breakdown risk, a sal State Examination) (30 to of cognitive function that and orientation, memory, calculation, language, and implex polygon), and a sal Medication assessment. Assessments were completed ministration Medication sident's Self-Administration ment questions, numbered 1 to completed. The sal Medication assessment inplete. The resident's Initial Level of Care) scoring dependent in his Medication second to the completed and current for every 6 months. She salf-administered his own regional Nurse Specialist ion self-administration for completed and current for get to self-administer his/her and admission and at least every				

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PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	CON	TE SURVEY MPLETED 02/2024
	PROVIDER OR SUPPLIEI		9210 M	ADDRESS, CITY, STATE, ZIP CO IAYSVILLE ROAD WAYNE, IN 46815	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<u> </u>	on of the self-administration				
	evaluation and self-	the completion of semi-annual administration medication wided by the facility by				
R 0217	410 IAC 16.2-5-2					
Bldg. 00	facility, using app members, shall id services to be profollows: (1) The services of resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as appropresident and facility	pletion of an evaluation, the ropriately trained staff entify and document the evided by the facility, as offered to the individual appropriate to the: offered shall be reviewed and oriate and discussed by the ty as needs or desires a facility or the resident may				
	request a service (3) The agreed up signed and dated of the service plan resident upon req (4) No identification services provided subsequent to the no need for a characteristic provision of residents both, is needed, as	plan review. pon service plan shall be by the resident, and a copy n shall be given to the uest. on and documentation of is needed if evaluations e initial evaluation indicate				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	B. WING			2024
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
OFDADI	UIDOT OF FORT W	/A\/\IE			IAYSVILLE ROAD		
CEDARF	HURST OF FORT W	VAYNE		FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on interview and record review the facility		R 02	217	Please indicate what actions		11/30/2024
	failed to ensure a cu	arrent, signed service plan was			the facility had taken to ensu	ire	
	completed for 5 of	5 residents reviewed (Resident			residents affected were		
	3, Resident 5, Resid	dent 2, Resident 4, and Resident			addressed. DON or designee	will	
	6).				review all resident's charts/EM		
					for signed Individualized Servi	ce	
	Findings include:				Plans (ISP). Any resident foun		
					out of compliance will have an		
	1) Resident 3's record was reviewed on 4/30/24 at				updated service plan complete		
	10:31 AM. Diagnoses included anxiety disorder,				and signed within 14 days of b		
	unspecified, hypothyroidism, major depressive				found out of compliance.	Ü	
	disorder, single episode, unspecified, unspecified				Please indicate the actions the	ne	
	dementia, unspecified severity, without behavioral				facility has taken to ensure n	10	
	disturbance, psycho	otic disturbance, mood			other residents were affected		
	disturbance, and an	xiety.			by the alleged deficient		
		•			practice. DON or designee wi	II	
	Resident 3's current	t Individualized Service Plan			monitor all resident charts mo		
	(ISP) document dat	ed 8/23/23 indicated the next			x 2 months and continue all ne	•	
	review date was 11	/27/23. The document was not			resident charts monthly.		
	signed or dated by	Resident 3 or her			Please indicate who is		
	representative. Doo	cumentation of any review of			responsible, the duration and	d	
	the ISP with Reside	ent 3 or her representative was			frequency of monitoring to		
	not available for rev	view.			prevent recurrence.		
					DON, ADON, or designee is		
	2) Resident 5's rec	ord was reviewed on 5/1/24 at			responsible for monitoring.		
	10:16 AM. Diagno	ses included acute diastolic			Please explain the role the		
	(congestive) heart f	ailure, aphasia, dementia in			facility quality assurance		
	other diseases class	ified elsewhere, moderate,			program will have in the		
	with agitation.				on-going monitoring process	s to	
					ensure this deficiency does i		
	Resident 5's current	t Individualized Service Plan			recur. How often will the		
	(ISP) document dat	ed 8/22/23 indicated the next			Quality Assurance program		
	review date was 12	/3/23. The document was not			review monitoring and for wh	nat	
	signed or dated by	Resident 5 or her			length of time? DON, ADON,		
		cumentation of any review of			designee will continue to moni		
	the ISP with Reside	ent 5 or his representative was			and update as needed based		
	not available for rev	view. 3) Resident 2's record			residents individual needs.		
	was reviewed on 4/	30/24 at 10:25 AM. Diagnoses					
		subdural hemorrhage, fracture					
		of neck of right femur, history					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/02/2024	
	PROVIDER OR SUPPLIEI		9210 M	ADDRESS, CITY, STATE, ZIP COD MAYSVILLE ROAD WAYNE, IN 46815	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	of falls, stage 3 chr	onic kidney disease, moderate chotic disturbance, and disorder.	TAG	DEFICIENCY	DATE
	Condition Complet 07/30/2024" indica assessment was the hospice on 9/20/23 ISP Change in Conby Resident 2 or he documentation of c facility and Resider concerning the ISP	t ISP titled, "ISP Change in ed On: 02/01/2024 Next Due On: ted the reason for the resident was admitted to and not completed timely. The dition was not signed or dated or representative. No ommunication between the nt 2 or her representative Change of Condition could be ovided by the facility for review			
	1:43 PM. Diagnoso mellitus, primary h weakness, abnorma	ord was reviewed on 5/1/24 at es included dementia, diabetes ypertension, generalized muscle al gait and mobility, unsteady tic subdural hemorrhage with ess.			
	Complete On: 02/1 was not signed or d representative. No communication bet 4 or his representat	ween the facility and Resident ive concerning the Initial ISP or was provided by the facility			
	11:23 AM. Diagno	ord was reviewed on 5/1/24 at oses included moderate attion and generalized anxiety			
		t ISP titled, "ISP Service Plan 2/2023 Next Due On:			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPL: 05/02/	ETED	
	ROVIDER OR SUPPLIER		9210 M	ADDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD VAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	
	ISP was due to be courrent IPS was not or her representative communication betw 6 or her representative be located nor was preview by facility extended in the located nor was preview by facility extended in the located nor was preview by facility extended in the located nor was preview by facility extended in the located nor representative. A current policy title policy & Procedures Regional Nurse Specinitial assessment are prompt initial ISPs a indicated if a resident change of condition ISP would be updated the resident or resident or resident or resident properties and the located in the located	/2/24 at 12:12 PM, the cialist indicated service plans , signed, and dated by the tative and facility staff. ed, " Individual Service Plan ", undated, provided by the cialist indicated resident's and the on-going assessments and updates. The policy at experiences a significant preference, or service(s) the ed, reviewed, and signed by ent's representative.				
R 0241	410 IAC 16.2-5-4(e)(1)				
Bldg. 00	provision of reside as ordered by the shall be supervised the premises or or (1) Medication shall licensed nursing p medication aides.	tion of medications and the ntial nursing care shall be resident 's physician and d by a licensed nurse on	R 0241	Please indicate what actions		11/30/2024
	review the facility fa	ailed to ensure documentation ordered by a physician for 1	K U241	the facility had taken to ensu residents affected were		11/30/2024

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
			B. W	ING		05/02/2024	
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		1			
CEDABL	IURST OF FORT W	/AVNE	9210 MAYSVILLE ROAD FORT WAYNE, IN 46815				
CEDARI	IURST OF FORT W	VATINE		FORT	VATNE, IN 40815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	ON
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	of 5 residents review	wed. (Resident 4).			addressed. Current/most rece	nt	
	Findings include:				office visit notes with current		
					diagnoses and medication list		
					requested from providers of al	l	
	In an interview on 4	4/30/24 at 2:10 PM Resident 4			residents.		
		stered his own medication. He			Please indicate the actions the	ne	
		ations were in a medication box			facility has taken to ensure n	0	
	filled by his daught	er once a week.			other residents were affected	I	
					by the alleged deficient		
	-	ion on 4/30/24 at 2:10 PM,			practice. Current/most recent		
	Resident 4 pointed to a black metal medication box				office visit notes with current		
		nches by 14 inches sitting on			diagnoses and medication list		
	-	ounter.He indicated the			requested from providers of al		
	medication box disp	pensed his medication for him.			residents.		
					Please indicate who is		
		was reviewed on 5/1/24 at 1:43			responsible, the duration and	i	
	-	luded dementia, diabetes			frequency of monitoring to		
		ypertension, generalized muscle			prevent recurrence.		
		l gait and mobility, unsteady			DON, ADON or designee are		
		tic subdural hemorrhage with			responsible for monitoring.		
	loss of consciousne	SS.			Please explain the role the		
	5				facility quality assurance		
	Resident 4's current				program will have in the		
		Initial Assessment" dated			on-going monitoring process	l l	
	-	eted by LPN 10. Resident 4's			ensure this deficiency does	not	
		included assessments for: fall			recur. How often will the		
		factors, skin breakdown risk, a			Quality Assurance program		
		al State Examination) (30			review monitoring and for wi		
	•	t of cognitive function that			length of time? DON, ADON	l l	
		and orientation, memory, calculation, language, and			designee will obtain POS on a	II	
					residents quarterly. Quality		
	-	mplex polygon), and an Medication assessment.			Assurance will review Quarter collection of medication lists.	y	
		Assessments were completed			conection of medication ilsts.		
		ninistration Medication					
	_	sident's Self-Administration					
		nent questions numbered 1					
	through 17 were no	-					
	_	n Medication assessment					
		nplete. The resident's Initial					
	108uns were not cor	npiete. The resident's illitial					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/02/2024	
	PROVIDER OR SUPPLIEI			9210 MA	DDRESS, CITY, STATE, ZIP COD AYSVILLE ROAD /AYNE, IN 46815		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	P	ID PROVIDER'S PLAN OF CORRECTION PROFILE OF THE ADDRESS PRESERVING TO		TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
	1	Level of Care) scoring dependent in his Medication					
	Resident 4's current physician orders indicated no resident medication appeared on the orders.						
	Regional Nurse Spself-administered hindicated a resident obtained on admission medications needed resident's who self-Regional Nurse Sporders were available would check on the floor nursing staff of the computer. A current policy tit Administration Policy provided by the Reform provided medication medication medication medication.	5/2/24 at 12:12 PM, the ecialist indicated Resident 4 is own medication. She is medication list should be ions but was unaware if to be entered as orders for administer medications. The ecialist indicated no medication of the for Resident 4 and she is computer. She indicated the fid not have access to files on led, "Medication icy & Procedures", undated, gional Nurse Specialist on it, indicated if the Community in administration the cation policies and procedures					
	addressed self-adm No other policy for medication(s) in medication	by a physicianand inistration of medication. documentation of resident's edication orders or physician d by the facility by survey exit.					
R 0273	410 IAC 16.2-5-5						
Bldg. 00	(f) All food prepar (excluding areas maintained in acc	nal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and nd safe food handling ng 410 IAC 7-24.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
			B. WING 05/02/2024			/2024	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					MAYSVILLE ROAD		
CEDARH	IURST OF FORT W	/AYNE		FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION	OVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	Based on observation, interview, and record		R 0	273	Please indicate what actions		11/30/2024
	review the facility failed to ensure kitchen			_,_	the facility had taken to ensu	ıre	
		tained. 66 of 66 residents			residents affected were		
	residing in the facil	ity ate food prepared in the			addressed.		
	kitchen.				/p>		
	Findings include:				Please indicate the actions t	he	
					facility has taken to ensure r		
					other residents were affected		
	During an observati	ion and interview on 4/30/24 at			by the alleged deficient		
	9:05 AM, two open, unlabeled, undated bags of				practice. The ice scoop and tra	ash	
	-	ed in the dry storage area of the			receptacle have been relocate		
		dicated she was unable to find			and the team educated on this		
	a label and date on	the cereal bags. A bag of			event. The Dining Services		
	baking cocoa was o	bserved on a shelf open and			Director will do bi-weekly chec	ks	
	unsealed. Cook 8 in	dicated products should never			of all items and in-service		
		e product exposed. 2 open			education will be provided to d	dining	
	undated containers	of ice cream were observed in			staff within 30 days regarding	Ū	
	the walk-in freezer.	The Director of Dining			proper food documentation an	ıd	
	Services indicated t	he ice cream belonged to the			storage. The Dining Services		
	activity staff and sh	ould have been dated when			Director will use the communit	y's	
	opened. An undated	l, unlabeled tray of 21 lidded			monthly cleaning schedule an	-	
	individual plastic cu	ups with creamy textured food			stay current on the kitchen's		
	substances was obs	erved in the reach in cooler.			monthly cleaning list.		
	The Director of Dir	ing Services indicated the			Please indicate who is		
		vidual servings of salad			responsible, the duration and	d	
	dressings. The Dire	ctor of Dining Services			frequency of monitoring to		
	indicated the staff d	id not routinely label and date			prevent recurrence. DSD is		
	the salad dressing c	ups.			responsible for monitoring.		
					Please explain the role the		
	An ice machine was	s observed in the kitchen. The			facility quality assurance		
	ice machine had an	ice scoop container affixed to			program will have in the		
	the front of the mac	hine and contained an ice			on-going monitoring process	s to	
	scoop. A trash can	was observed positioned next			ensure this deficiency does	not	
	to the ice machine,	about 5 inches from the			recur. How often will the		
	machine. Red- and cream-colored streaks and				Quality Assurance program		
	drops in a splatter pattern, too many to count,				review monitoring and for w	hat	
	were observed on the side of the ice machine				length of time?		
	adjacent to the trash can, on the front of the ice						
	machine and scoop	holder. The Director of					
	Dining Services ind	licated the trash can should					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVE COMPLETED 05/02/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL PLACE IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) IPLETION	
TAG	not be stored near the contamination of the A current policy titl Procedures, undated Operations Specialist Director or Designer all opened foods are daily. The policy in should be labeled wo for storage, use by deemployee initial. A current policy titl and Procedures, undated	the ice machine due to possible to ice supply. Ided Food Storage Policy and the provided by the Regional st indicated the Food Service to should inspect and ensure to properly dated and stored indicated all stored products with the name of the food, date ate, time of storage and the Cleaning Rotation Policy dated, provided by the Services indicated ice machines	TAG	DEFICIENCY	I	DATE	
D 0200	should be cleaned n	nonthly.					
R 0298 Bldg. 00	(2) A consultant plemployed, or under (A) be responsible in 856 IAC 1-7; (B) review the drug practices in the fact (C) provide consult procedures of order administering, and as medication record (D) report, in writing his or her designed dispensing or admition (E) review the drug (P) review the drug (P) report, in writing the dispensing or admition (E) review the drug (P) review the	ervices - Deficiency harmacist shall be er contract, and shall: e for the duties as specified g handling and storage cility; ltation on methods and ering, storing, d disposing of drugs as well					
	Based on interview, failed to ensure pha- every 60 days for 4	, and record review the facility rmacy reviews were completed of 5 residents reviewed nt 5, Resident 2, and Resident	R 0298	Please indicate what actions the facility had taken to ensuresidents affected were addressed. The community wi	ire	30/2024	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/02/2024	
	PROVIDER OR SUPPLIER HURST OF FORT WAYNE	9210 M	ADDRESS, CITY, STATE, ZIP COD IAYSVILLE ROAD WAYNE, IN 46815		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PEGLIA TORY OR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION 6). Findings include: 1) Resident 3's record was reviewed on 4/30/24 at 10:31 AM. Diagnoses included anxiety disorder, unspecified, hypothyroidism, major depressive disorder, single episode, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Consultant Pharmacist's Medication Regimen Reviews for Resident 3 dated 9/29/23 and 3/25/24. Pharmacy reviews due November and January for Resident 3 were not available for review. 2) Resident 5's record was reviewed on 5/1/24 at 10:16 AM. Diagnoses included acute diastolic (congestive) heart failure, aphasia, dementia in other diseases classified elsewhere, moderate, with agitation. Consultant Pharmacist's Medication Regimen Reviews for Resident 5 dated 8/2/23, 9/29/23, 11/24/23, and 3/27/24. Pharmacy reviews due in Joanuary for Resident 5 were not available for review.3) Resident 2's record was reviewed on 4/30/24 at 10:25 AM. Diagnoses included traumatic subdural hemorrhage, fracture of unspecified part of neck of right femur, history of	TAG	continue to follow policy and no sure pharmacy is sending continue to follow policy and not represent the sure pharmacy is sending continue to follow policy and not represent the sure pharmacy documentation is for provided timely. This is to take effect immediately. Please indicate the actions to facility has taken to ensure nother residents were affected by the alleged deficient practice. Community partnering with pharmacy for pharmacy consult to occur every 60 days. Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence. DON or designee is responsible for monitoring pharmacy consultation every 60 days. Please explain the role the facility quality assurance program will have in the on-going monitoring processensure this deficiency does recur. How often will the Quality Assurance program review monitoring and for will ength of time? Pharmacy will send pharmacy consultation end.	nake sult cy. e sult c	
	falls, stage 3 chronic kidney disease, moderate dementia with psychotic disturbance, and generalized anxiety disorder. Resident 2 was admitted on 8/25/23. The resident had a Consultant Pharmacist's Medication Regimen Review dated 4/1/24. Pharmacy reviews due October, Decmber, and February for Resident 2 were not provided by the facility for review by		60 days.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	COMPLETED 05/02/2024		
	ROVIDER OR SUPPLIER		9210 M	ADDRESS, CITY, STATE, ZIP COD IAYSVILLE ROAD WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	11:23 AM. Diagnos dementia with agitat disorder. Resident 6 was adm resident's last Consulting Regimen Review was reviews due Octobe. Resident 6 were not review by survey extended by Specialist on 5/2/24	/2/24 at 12:12 PM, the cialist indicated pharmacy completed at least every 60 nt. led, " Pharmacist Clinical Policy and Procedure", y the Regional Nurse at 1:04 PM, indicated resident viewed every sixty days in			
R 0349 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -	, , , ,			
	on each resident. maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on interview	These records must be the supervision of an acility designated with that records must be as umented.	R 0349	Please indicate what actions	11/30/2021

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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 <u>00</u>		COMPLETED		
			B. WI	NG		05/02/	
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					AYSVILLE ROAD		
CEDARH	HURST OF FORT W	VAYNE		FORT V	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	assessment was completed after an abuse				residents affected were		
	allegation for 1 of 3	3 residents reviewed (Resident			addressed.The community ha	ıs	
	5).				educated staff by in-servicing	on	
					the documentation process an	ıd	
	Findings include:				the importance of completing		
					documentation in a timely mar	nner.	
	During an interview	v on 4/30/24 at 2:40 PM, the			Starting 5/15/2024 and on-goi		
	Operations Specials	ist indicated she was in the			until 100% of staff have compl	eted	
	process of investiga	ating an abuse allegation and			this in-service. The Executive		
	was preparing to re	port it to the state office.			Director (ED) and Director of		
					Nursing (DON) completed		
	A report of the alle	gation provided by the			re-education on 5/15/2024		
	Operations Speciali	ist on 5/1/24 at 9:10 AM			regarding Cedarhurst		
	indicated Resident	5 had entered a female			communication expectation po	olicy	
	resident's room and	urinated on the floor. The			and procedures and Indiana S	state	
	female resident's hu	usband allegedly made contact			Department of Health long ter	m	
	with Resident 5.				care abuse and incident repor	ting	
					policy to include any event or		
	In an employee wit	ness statement provided by the			suspected event that occurs ir	n the	
		ist on 5/1/24 at 10:38 AM, on			community will be reported to	the	
		00 PM, Certified Nurse Aid 4			ED and DON immediately so a	an	
		ssisting Resident 5 out of a			investigation can be complete	d as	
		athroom he had wandered into			per Cedarhurst policy and Sta	te	
		ombative and sat in a chair. She			regulations.		
		nd of the resident residing in			Please indicate the actions the	_	
		ent 5 on the shoulder and			facility has taken to ensure n		
	pushed him as he ex	xited the room.			other residents were affected	t	
					by the alleged deficient		
		was reviewed on 5/1/24 at			practice.The community has		
	_	ses included acute diastolic			educated staff by in-servicing		
		ailure, aphasia, dementia in			the documentation process an	ıd	
		ified elsewhere, moderate,			the importance of completing		
	with agitation.				documentation in a timely mar		
	A 1	D 11 4 II 141 A			Starting 5/15/2024 and on-goi	-	
		Resident Health Assessment			until 100% of staff have compl	eted	
		incident dated 5/1/24, 3 days			this in-service. The Executive		
		incident, provided by the			Director (ED) and Director of		
		/1/24 at 2:10 PM indicated no			Nursing (DON) completed		
		vas observed upon assessment			re-education on 5/15/2024		
	of Resident 5. No i	resident observations or	1		regarding Cedarhurst		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/02/2024				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION 14/28/24 to 4/30/24 regarding	TAG	communication expectation p	DATE			
		lent 5's physical and		and procedures and Indiana	•			
		ng were available for review.		Department of Health long tell care abuse and incident repo	rm			
	A review of vital sign	gn records from 4/24/24 to		policy to include any event or	•			
		the Administrator on 5/1/24 at		suspected event that occurs i				
		vital signs were checked on		community will be reported to				
		M, 2 days prior to the date of		ED and DON immediately so				
	the incident. No oth	ner documented vital signs		investigation can be complete	ed as			
	were available for r	eview.		per Cedarhurst policy and Sta	ate			
				regulations.				
		5/1/24 at 10:38 AM, the		Please indicate who is				
		st indicated she was not aware		responsible, the duration an	d			
	-	being done to ensure the		frequency of monitoring to				
		onal well-being immediately		prevent recurrence. The				
	following the allege	ed incident on 4/28/24.		Executive Director and DON	are			
				responsible for sustained				
		led Abuse, Neglect, and		compliance.				
	-	ntion, Prohibition, and		Please explain the role the facility quality assurance				
		and Procedures, dated						
	-	y the Regional Director of		program will have in the on-going monitoring proces				
	_	d upon an abuse allegation,						
		ine if the resident is safe and the resident needed any		ensure this deficiency does not recur. How often will the				
		or supportive services. The						
		ff should complete an incident		Quality Assurance program review monitoring and for w	hat			
	report and document			length of time? The Executiv				
	10port and documen	it a critical floto.		Director and DON are respon				
				for sustained compliance.	GIBIO			
				Residents will be discussed a	t the			
				weekly ROAR meeting. This v				
				help with early identification of				
				residents at risk and trigger th				
				necessary follow-up measure				
				which could include meetings	with			
				families, notifications to				
				physicians, investigations, an	d			
				incident reporting if warranted	l.			
				This meeting will be held wee	kly			
				by the Executive				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 05/02/	ETED		
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
					Director/designee and DON/designee. The Executive Director and Business Office Manager will audit all new hire orientations weekly to ensure training on reportable events is completed. Monitoring will be ongoing.	:		
R 0357	410 IAC 16.2-5-8. Clinical Records -							
Bldg. 00	the resident's dea following: (1) Notification of the responsible perso (2) The disposition possessions, and (3) A complete and resident's condition Based on interview failed to ensure according	d accurate notation of the on and most recent vital ms preceding death. and record review the facility trate documentation of the preceding death and the nal belongings for 1 of 2	R 035	7	Please indicate what actions the facility had taken to ensure residents affected were addressed. The Executive Director of Nursing		11/30/2024	
	Findings include: An anonymous com Department of Heal	pplaint to the Indiana th indicated there was a nd-of-life care provided to			(DON) completed re-education 5/15/2024 regarding documentation and communication expectations policy and procedure. Staff has begun in-service on 5/15/2024	ve		
	Resident B. Resident B's record 10:52 AM. Diagnos failure, high blood p	was reviewed on 5/1/24 at es included chronic respiratory pressure and heart disease.			regarding documentation and communication expectations policy and procedur Staff will continue documenting progres notes on resident until residen remains are picked up. This is take effect immediately Please	es t to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/02/2024				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815					
	SUMMARY (EACH DEFICIENT REGULATORY OF indicated Resident at 5:20 PM with far remains had been really regional Nurse Specialist with Indian requirements. The I indicated the facility release of resident at Specialist indicated the release of personal Nurse Specialist indicated the release of personal Nurse PM indicated all the should be placed in	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ALSC IDENTIFYING INFORMATION B was actively dieing. ed 12/6/23 at 8:00 PM B had passed away on 12/6/23 mily at bedside. Resident B's eleased at or around 7:30 PM. e provider and physician were 5/2/24 at 10:35 AM the excialist indicated they were not na death documentation Regional Nurse Specialist by did not use a form for the remains. The Regional Nurse the facility did not document nal belongings. policy dated 9/26/22 provided by Specialist on 5/2/24 at 12:02 the deceased resident's records			DATE O DATE DATE O DATE O DATE O DATE DATE O DATE O DATE O DATE DATE			
				follow-up measures which cou include meetings with families notifications to physicians,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING						
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				investigations, and incident reporting if warranted. This meeting will be held weekly by Executive Director/designee a DON/designee. The Executiv Director and Business Office Manager will audit all new hire orientations weekly to ensure training on reportable events i completed. Monitoring will be ongoing.	e e			
R 0407 Bldg. 00	control program the (1) A system that analyze patterns of symptoms. (2) Provides orienteducation on infecting universal (3) Offering health including, but not transmission and	Noncompliance st establish an infection nat includes the following: enables the facility to of known infectious tation and in-service ction prevention and control, I precautions. information to residents, imited to, infection immunizations. municable disease to						
	Based on record rev failed to ensure the analyzed patterns, to ensured antibiotic stresided in the facility. Findings include: A current undated preference (General) Policy & Regional Nurse Specindicated staff would	riew and interview the facility infection control program racked, trended infections, and tewardship. 66 residents	R 0407	Please indicate what actions the facility had taken to ensuresidents affected were addressed. /p> Please indicate the actions to facility has taken to ensure rother residents were affected by the alleged deficient practice. Infection logs will be maintained on a monthly basis and will track infection type, treatment, and follow up need	he no d			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/02/2024			
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	of Disease Control No infection control rack ongoing trend antibiotic stewards in the policy. A current policy tit Outbreak Policy & provided by the Re 5/1/24 at 10:40 AM would be reviewed infection when the outbreak and staff's control practices. It analyze patterns, tr infectious sympton the facility was loc A current policy tit Precaution Policy & provided by the Re 5/1/24 at 10:40 AM program informatio ongoing trends of it antibiotic stewards A current policy tit Procedures", updat Regional Nurse Sp indicated alert char resident's with infer The policy indicate charting would be completed for 72 h Wellness or Licens charting. No infect patterns, track onge	led, "Universal/Standard & Procedures", undated, gional Nurse Specialist on I, provided no infection control on to analyze patterns, track infectious symptoms and hip in the facility. led, "Alert Charting Policy & ed 5/2/24, provided by the ecialist on 5/2/24 at 12:01 PM, ting would be completed for ctions and/or new medications. It is to be a control program to analyze or on the letter of the Nurse discontinues the alert ction control program to analyze or on the letter of the letter o		Tracking will provide the trend infections and tragoing forward. Please indicate who is responsible, the durate frequency of monitors prevent recurrence. It responsible for monitors please explain the rost facility quality assurate program will have into on-going monitoring ensure this deficient recur. How often will Quality Assurance proview monitoring and length of time? DON, designee will update at the infection log as we up with providers as not further treatments. This ongoing.	eatments is ation and ring to DON is oring. Ile the ance the process to y does not the rogram ad for what ADON, or and maintain ell as follow eeded for			

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED		
			B. W	B. WING			05/02/2024	
				·				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
					AYSVILLE ROAD			
CEDARH	URST OF FORT W	AYNE		FORT	WAYNE, IN 46815			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DE CLUDEDIG DE ANI CE CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	iE	DATE	
	In an interview on 5	5/2/24 at 12:12 PM, the						
		ecialist indicated the facility						
	-	y on tracking, trending of						
	infections and antib							
	micetions and antic	ione ase.						
R 0409	410 IAC 16.2-5-12	2(d)						
	Infection Control -	, ,						
Bldg. 00		sion, each resident shall be						
	required to have a health assessment,							
	including history of significant past or present							
	infectious diseases and a statement that the							
	resident shows no evidence of tuberculosis in							
	an infectious stage as verified upon							
	admission and yearly thereafter.							
	Based on interview and record review the facility		R 0409		Please indicate what actions		11/30/2024	
	failed to ensure current annual health statements			107	the facility had taken to ensure		11/30/2024	
	were completed and current for 4 of 5 residents				residents affected were			
	-	3, Resident 5 and Resident 2			addressed.			
	and Resident 6).				="" span			
	Findings include:				Please indicate the actions the	16		
					facility has taken to ensure n			
					other residents were affected			
	1) Resident 3's reco	ord was reviewed on 4/30/24 at			by the alleged deficient	'		
	,	es included anxiety disorder,			practice. Updated Physician			
	•	yroidism, major depressive			Certifications have been reque	eted		
		sode, unspecified, unspecified			from resident's PCP.	Jolea		
		ed severity, without behavioral			Please indicate who is			
	-	tic disturbance, mood			responsible, the duration and	1		
	disturbance, and an				frequency of monitoring to	•		
	distarbance, and an	nety.			prevent recurrence. DON,			
	A Document titled I	Physician's Assessment,			ADON, or designee will monitor	nr		
		and Certification dated			paperwork on incoming reside			
	• •	nealth statement section to			as well as updated documenta			
		esident 3 was free of			as needed on an ongoing basi			
		ase. The section was not			Please explain the role the			
		rm. No other documents			facility quality assurance	ļ		
	-	ent of freedom from			program will have in the	ļ		
	_	ase for Resident 3 were			on-going monitoring process	s to		
	available for review				ensure this deficiency does			
	a. anacie for feview	•	1		Should this deliciency does i	.51	l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/02/2024			
	NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815				
(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)			(X5) COMPLETION DATE		
	10:16 AM. Diagnot (congestive) heart for the diseases class with agitation. A Document titled	ord was reviewed on 5/1/24 at ses included acute diastolic ailure, aphasia, dementia in ified elsewhere, moderate, Physician's Assessment,			nce program ng and for what DON/DOS will be nonitoring. This			
	History and Physical and Certification dated 4/14/23 included a health statement to indicate Resident 5 was free of communicable disease. No other documents containing a statement of freedom from communicable disease for Resident 3 were available for review.3) Resident 2's record was reviewed on 4/30/24 at 10:25 AM. Diagnoses included traumatic subdural hemorrhage, fracture of unspecified part of neck of right femur, history of falls, stage 3 chronic kidney disease, moderate dementia with psychotic disturbance, and generalized anxiety disorder. Resident 2's Physician's Assessment, History and Physical and Certification, dated 11/19/23, was completed by her Nurse Practitioner (NP) and included a medical history. One section of her medical history asked, "Is resident free from communicable diseases?" with the option of the resident's NP to check a yes or no box. The section of the medical history was not completed as neither the yes nor no box was checked. Resident 2's physician orders contained no order to indicate the resident was free from infectious/communicable diseases.							
	(PCP) statement to from infectious/con	ining a primary care provider's indicate Resident 2 was free nmunicable diseases was ility for review by survey exit.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE : COMPL 05/02/	ETED		
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		P.	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	4) Resident 6's record was reviewed on 5/1/24 at 11:23 AM. Diagnoses included moderate dementia with agitation and generalized anxiety disorder.							
	Resident 2's Physician's Assessment, History and Physical and Certification, undated, was completed by her Nurse Practitioner-Certified (NP-C). The document indicated the assessment was the resident's yearly assessment. The document included a medical history and one section of her medical history asked, "Is resident free from communicable diseases?" with the option of the resident's NP-C to check a yes or no box. The section of the medical history was not completed as neither the yes nor no box was checked.							
	Resident 6's physic to indicate the resid infectious/commun							
	No documents containing a PCP's statement indicating Resident 6 was free from infectious/communicable diseases was provided by the facility for review by survey exit. In an interview on 5/2/24 at 12:12 PM, the Regional Nurse Specialist indicated annual health statements were not completed and current. She indicated the health statements should be completed annually and kept current. A current undated policy titled, "Assessment Policy & Procedure", provided by the Regional Nurse Specialist on 5/2/24 at 12:01 PM indicated residents of the Community would be assessed according to State regulations or according to the facility's policy, whichever was stricter. The policy indicated residents would be assessed by a							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ĺ	ILDING	ONSTRUCTION 00	(X3) DATE COMPL 05/02 /	ETED
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 9210 MAYSVILLE ROAD FORT WAYNE, IN 46815				
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility and on an ar	0 days prior to moving into the nual basis with the nent, History and Physical, &					
	1 ,	completion of annual health nary care provider was ility by survey exit.					

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