STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00431428. Complaint IN00431428 - State deficiencies related to the allegations are cited at R0357. Survey dates: April 30, May 1 and 2, 2024. Facility number: 014576 Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 6, 2024	R 0000	see attached.	
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Winchell	Regional Director of Nursing	07/22/2024

Any defiencystatement 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	(A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals 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 ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D).			
	Based on interview and record review, the facility failed to ensure transfer documentation was complete for 1 of 2 residents reviewed (Resident 8). Findings include: Resident 8's record was reviewed on 5/1/24 at 9:20 AM. Diagnoses included bipolar disorder and major depressive disorder with psychotic symptoms. A progress note dated 11/13/24 at 10:30 AM	R 0044	**Please indicate what actions the facility had taken to ensure residents affected were addressed Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.** **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** DON or designee will review	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident 8 had refused breakfast. A progress note dated 11/21/23 at 3:45 PM indicated Resident 8 did not see the podiatrist on 11/20/23 due to the resident being in the hospital. Resident 8 had no progress notes dated 11/14/23 through 11/20/24 to indicate the resident had been admitted to the hospital, why or any notifications to the responsible party. A progress note dated 11/29/23 at 10:00 PM indicated charting continued due to Resident 8 being readmitted. There were no progress notes to indicate date and time of readmission. A progress note dated 11/30/23 at 1:15 PM indicated charting continued due to Resident 8 being readmitted.There were no progress notes to indicate date and time of readmission. A progress note dated 11/30/23 at 9:45 PM indicated charting continued due to Resident 8 being readmitted.There were no progress notes to indicate date and time of readmission. A progress note dated 1/13/24 at 11:30 AM indicated Resident 8 had a flat facial expression and did not engage in conversation. Resident 8 had been resistant to care. Resident 8 had not been eating, drinking, or sleeping well. Resident 8's apartment was soiled with waste as they had not been letting the dog out. Resident 8's Power of Attorney (POA) was updated on the resident's condition. A progress note dated 1/16/24 at 11:15 AM indicated Resident 8 refused to get out of bed and refused care. Resident 8 was transferred to the hospital by an ambulance due to continuing		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 to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** DON is responsible for sustained compliance. Monitoring will be on-going for 3 months. The Quality Assurance Team will review during ROAR monthly to determine if continued auditing is necessary based on 3 consecutive months of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	psychiatric decline. A progress note dated 3/5/24 at 3:24 PM indicated Resident 8 had been discharged to hospice care. Resident 8 had no progress notes dated 1/17/24 through 3/4/24. In an interview on 5/2/24 at 12:10 PM the Regional Nurse Specialist indicated the facility did not use transfer forms when residents were transferred to the hospital. The Regional Nurse Specialist indicated transfer documentation should include resident condition, the reason for the transfer, the date, the time, and the location of the receiving facility. In an interview on 5/2/24 at 2:25 PM the Regional Nurse Specialist indicated hospital transfer information was documented in a Resident Status Log. On 5/2/24 at 2:33 PM the Regional Nurse Specialist provided Resident 8's Resident Status Log. The status log indicated Resident 8 was taken to the emergency room by their daughter on 11/13/23 at 7:29 PM. The status log indicated Resident 8 had been admitted to the hospital on 11/14/23 at 6:54 PM. The status log indicated Resident 8 was at the emergency room on 1/16/24 at 5:46 PM. The status log indicated Resident 8 was admitted to the hospital on 1/16/24 at 5:46 PM. The status log indicated Resident 8 was discharged from the facility and moved to hospice care on 3/5/24 at 3:24 PM. In an interview on 5/2/24 at 12:10 PM the Regional			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	Nurse Specialist indicated the facility did not have a policy for transfer documentation or notofications. 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review the facility failed to ensure protection from physical abuse after an abuse allegation for 1 of 5 reviewed (Resident 5). Findings include: 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. In an employee statement dated 4/30/24 provided by the Operations Specialist on 5/1/24 at 10:38			
R 0052 Bldg. 00		R 0052	**Please indicate what actions the facility had taken to ensure residents affected were addressed.** /p> **Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.** The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/15/2024 regarding Cedarhurst communication expectation policy and procedures and Indiana State Department of Health long term care abuse and incident reporting policy to include any event or suspected event that occurs in the community will be reported to the ED and DON immediately so an investigation can be completed as per Cedarhurst policy and State regulations. **Please indicate who is responsible, the duration and frequency of monitoring to**	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	AM, on 4/28/24 at about 6:00 PM, Certified Nurse Aid (CNA) 4 indicated she was assisting Resident 5 out of a female resident's bathroom he had wandered into when he became combative and sat in a chair. She indicated the husband of the resident residing in the room hit Resident 5 on the shoulder and pushed him as he exited the room. In an undated employee statement provided by the Operations Specialist on 5/1/24 at 10:38 AM, Qualified Medicine Aide (QMA) 5 indicated she heard a resident's husband yelling "get out, get out" as Resident 5 had wandered into his wife's bathroom and urinated on the floor. She indicated the resident's husband escorted Resident 5 out of the room. She did not report the incident because Resident 5 wasn't harmed. She indicated Resident 5 regularly wandered into rooms and urinated. The statement did not include any immediate action to escort the family member alleged to have abused Resident 5 from the unit to maintain separation from Resident 5. In an employee statement dated 4/30/24, provided by the Operations Specialist on 5/1/24 at 10:38AM, Qualified Medicine Aide (QMA) 6 indicated a staff member told her she had reported an allegation of abuse to the QMA on the prior shift (QMA 5) but she did not take any action or report it. QMA 6 indicated she reported what she was told to the Resident Care Manager (RCM) on 4/28/24 around 8:00 PM. QMA 6 also indicated she passed the information in shift change to QMA 3 on the morning of 4/29/24. In an interview on 5/1/24 at 10:38 AM, the Operations Specialist indicated she was notified of the incident on 4/29/24. She was made aware the family member involved in the allegation was present on the unit visiting around 2:30 PM,		**prevent recurrence.** The Executive Director and DON are responsible for sustained compliance. Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time? Residents will be discussed at the weekly ROAR meeting. This will help with early identification of residents at risk and trigger the necessary follow-up measures which could include meetings with families, notifications to physicians, investigations, and incident reporting if warranted. This meeting will be held weekly 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 is completed. Monitoring will be ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	escorted him from the unit, obtained a written statement from him and informed him of his inability to visit on the unit until the investigation was completed. She indicated the family member involved in the allegation would not have been allowed to visit the unit where the Resident 5 resided if she had been notified of the incident immediately per protocol. A current policy titled Abuse, Neglect, and Exploitation Prevention, Prohibition, and Investigation Policy and Procedures, dated 3/14/22, provided by the Regional Director of Operations indicated upon an abuse allegation, the person allegedly abusing the resident should be separated from the resident immediately.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review the facility failed to ensure an allegation of abuse was reported in a timely manner for 1 of 3 residents reviewed (Resident 5). Findings include: During an interview on 4/30/24 at 2:40 PM, the Operations Specialist indicated, on 4/28/24, there was an allegation of abuse. She was in the process of investigating the abuse allegation and was preparing to report it to the state office.	R 0090	**Please indicate what actions the facility had taken to ensure residents affected were addressed Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.** **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** The Executive Director and DON	05/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	A report of the allegation provided by the Operations Specialist on 5/1/24 at 9:10 AM indicated on 4/28/24 at about 6:00 PM, 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. In an employee statement dated 4/30/24 provided by the Operations Specialist on 5/1/24 at 10:38 AM, Certified Nurse Aid (CNA)4 indicated she was assisting Resident 5 out of a female resident's bathroom he had wandered into when he became combative and sat in a chair. She indicated the husband of the resident residing in the room hit Resident 5 on the shoulder and pushed him as he exited the room. In an employee statement dated 4/30/24 provided by the Operations Specialist on 5/1/24 at 10:38AM, Qualified Medicine Aide (QMA) 6 indicated a staff member told her she had reported an allegation of abuse to the QMA on the prior shift and she did not take any action or report it. QMA 6 indicated she reported what she was told to the Resident Care Manager (RCM) on 4/28/24 around 8:00 PM. QMA 6 also indicated she passed the information in shift change report to QMA 3 on the morning of 4/29/24. In an employee statement dated 4/30/24 provided by the Operations Specialist on 5/1/24 at 10:38 AM, the RCM indicated QMA 6 reported to her that an abuse allegation was reported to her. No further reporting to any other member of the		are responsible for sustained compliance. **Please explain the role the facility quality assurance program will have in the on-going process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** The Executive Director is responsible for sustained compliance. Residents will be discussed at the weekly ROAR meeting. This will help with early identification of residents at risk and trigger the necessary follow-up measures which could include meetings with families, notifications to physicians, investigations, and incident reporting if warranted. This meeting will be held weekly 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 is completed. Monitoring will be ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	management team was addressed in the statement. In an interview on 5/1/24 at 10:38 AM, the Operations Specialist indicated she was notified of the incident on 4/29/24, but did not report the indcident through the IDOH channels. She indicated staff should ensure the resident's safety and then immediately report any allegations of abuse to the Director of Nursing and Administrator. The Director of Nursing and Administrator should then notify Corporate Support staff immediately. In an interview on 5/2/24 at 10:38 AM, the Regional Director of Operations indicated the management team became aware of the incident in the morning meeting on 4/29/24 when a staff member assigned to Resident 5's care reported it. A current policy titled Abuse, Neglect, and Exploitation Prevention, Prohibition, and Investigation Policy and Procedures, dated 3/14/22, provided by the Regional Director of Operations indicated any act performed intentionally or recklessly that causes or is likely to cause harm to a resident, such as hitting, constitutes abuse. The policy indicated alleged abuse should be immediately reported to a supervisor and Executive Director or Designee.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review the facility failed to ensure a First Aid and cardiopulmonary resuscitation (CPR) certified staff member was onduty at all times for 5 of 7 days reviewed. Findings include: A review of the previous 7-day schedule of actual hours worked dated 4/25/24 through 5/1/24 indicated there was not a First Aid and CPR certified staff member on duty for the following dates and times: 4/25/24- second shift, 4/26/24- second shift, 4/27/24- third shift, 4/29/24- second shift and 4/30/24- second shift. In an interview on 5/2/24 at 1:25 PM the Regional Operations Specialist indicated they were unaware of a regulation regarding a CPR and First Aid certified staff member not on duty at all times. The Regional Operations Specialist indicated the facility should always have a staff member with CPR and First Aid certification on duty. The Regional Operations Specialist indicated the	R 0117	**Please indicate what actions the facility had taken to ensure residents affected were addressed Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice**. Audit of all active employee files to determine compliance with CPR requirements. Employees found out of compliance have been instructed to complete CPR or they will be removed from the schedule until it is completed. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** The Executive Director/ BOM is responsible for sustained compliance.	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	facility did not have a policy related to CPR and First Aid certification.		**Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** The Executive Director and Business Office Manager will audit all new hire files weekly. Monitoring will be ongoing. Percentage goal for compliance is 100%.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review the facility failed to ensure semi-annual evaluations were completed for 2 of 5 residents reviewed (Resident 5 and Resident 4). Findings include: 1) Resident 5's record was reviewed on 5/1/24 at	R 0216	**Please indicate what actions the facility had taken to ensure residents affected were addressed.** DON/designee will complete assessments weekly to ensure assessments are updated and on time until 100 compliance is reached. Self-Administered	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	Community staff. Resident 4's current Move-in/6 Month Assessment titled "Initial Assessment" dated 1/29/24 was completed by LPN 10. Resident 4's Initial Assessment included assessments for: fall risk, elopement risk factors, skin breakdown risk, a MMSE (Mini Mental State Examination) (30 question assessment of cognitive function that evaluates attention and orientation, memory, registration, recall, calculation, language, and ability to draw a complex polygon), and a Self-Administration Medication assessment. Resident 4's Initial Assessments were completed except his Self-Administration Medication assessment. The resident's Self-Administration Medication assessment questions, numbered 1 through 17 were not completed. The Self-Administration Medication assessment results were not complete. The resident's Initial Assessment LOC (Level of Care) scoring indicated he was independent in his Medication Management. In an interview on 5/2/24 at 12:12 PM, the Regional Nurse Specialist indicated semi-annual evaluations should be completed and current for all residents at least every 6 months. She indicated Resident 4 self-administered his own medication. The Regional Nurse Specialist indicated a medication self-administration assessment should be completed and current for any resident wishing to self-administer his/her own medications on admission and at least every 6 months. A current policy titled, "Medication Administration Policy & Procedures", undated, provided by the Regional Nurse Specialist on 5/2/24 at 12:01 PM did not provide information			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	related to completion of the self-administration medication assessment. No other policy for the completion of semi-annual evaluation and self-administration medication assessment was provided by the facility by survey exit.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview and record review the facility failed to ensure a current, signed service plan was completed for 5 of 5 residents reviewed (Resident 3, Resident 5, Resident 2, Resident 4, and Resident 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. Resident 3's current Individualized Service Plan (ISP) document dated 8/23/23 indicated the next review date was 11/27/23. The document was not signed or dated by Resident 3 or her representative. Documentation of any review of the ISP with Resident 3 or her representative was 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. Resident 5's current Individualized Service Plan (ISP) document dated 8/22/23 indicated the next review date was 12/3/23. The document was not signed or dated by Resident 5 or her representative. Documentation of any review of the ISP with Resident 5 or his representative was 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	R 0217	**Please indicate what actions the facility had taken to ensure residents affected were addressed**. DON or designee will review all resident's charts/EMR for signed Individualized Service Plans (ISP). Any resident found out of compliance will have an updated service plan completed and signed within 14 days of being found out of compliance. **Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.** DON or designee will monitor all resident charts monthly x 2 months and continue all new resident charts monthly. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** DON, ADON, or designee is responsible for monitoring. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** DON, ADON, or designee will continue to monitor and update as needed based on residents individual needs.	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	of falls, stage 3 chronic kidney disease, moderate dementia with psychotic disturbance, and generalized anxiety disorder. Resident 2's current ISP titled, "ISP Change in Condition Completed On: 02/01/2024 Next Due On: 07/30/2024" indicated the reason for the assessment was the resident was admitted to hospice on 9/20/23 and not completed timely. The ISP Change in Condition was not signed or dated by Resident 2 or her representative. No documentation of communication between the facility and Resident 2 or her representative concerning the ISP Change of Condition could be located nor was provided by the facility for review by facility exit. 4) Resident 4's record was reviewed on 5/1/24 at 1:43 PM. Diagnoses included dementia, diabetes mellitus, primary hypertension, generalized muscle weakness, abnormal gait and mobility, unsteady on feet, and traumatic subdural hemorrhage with loss of consciousness. Resident 4's current ISP titled, "Initial ISP Complete On: 02/14/2024 Next Due On: 08/12/202" was not signed or dated by Resident 4 or his representative. No documentation of communication between the facility and Resident 4 or his representative concerning the Initial ISP could be located nor was provided by the facility for review by facility exit. 5) 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 6's current ISP titled, "ISP Service Plan Complete On: 08/22/2023 Next Due On:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	11/20/2023" was overdue. The resident's current ISP was due to be completed on 2/22/24. The current IPS was not signed or dated by Resident 6 or her representative. No documentation of communication between the facility and Resident 6 or her representative concerning the ISP could be located nor was provided by the facility for review by facility exit. In an interview on 5/2/24 at 12:12 PM, the Regional Nurse Specialist indicated service plans should be up to date, signed, and dated by the resident or representative and facility staff. A current policy titled, " Individual Service Plan Policy & Procedures", undated, provided by the Regional Nurse Specialist indicated resident's initial assessment and the on-going assessments prompt initial ISPs and updates. The policy indicated if a resident experiences a significant change of condition, preference, or service(s) the ISP would be updated, reviewed, and signed by the resident or resident's representative. No other policy for an ISP was provided by the facility by survey exit.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview, observation, and record review the facility failed to ensure documentation of medications were ordered by a physician for 1	R 0241	**Please indicate what actions the facility had taken to ensure residents affected were**	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	of 5 residents reviewed. (Resident 4). Findings include: In an interview on 4/30/24 at 2:10 PM Resident 4 indicated he administered his own medication. He indicated his medications were in a medication box filled by his daughter once a week. During an observation on 4/30/24 at 2:10 PM, Resident 4 pointed to a black metal medication box approximately 14 inches by 14 inches sitting on top of his kitchen counter.He indicated the medication box dispensed his medication for him. Resident 4's record was reviewed on 5/1/24 at 1:43 PM. Diagnoses included dementia, diabetes mellitus, primary hypertension, generalized muscle weakness, abnormal gait and mobility, unsteady on feet, and traumatic subdural hemorrhage with loss of consciousness. Resident 4's current Move-in/6 Month Assessment titled "Initial Assessment" dated 1/29/24, was completed by LPN 10. Resident 4's Initial Assessment included assessments for: fall risk, elopement risk factors, skin breakdown risk, a MMSE (Mini Mental State Examination) (30 question assessment of cognitive function that evaluates attention and orientation, memory, registration, recall, calculation, language, and ability to draw a complex polygon), and a Self-Administration Medication assessment. Resident 4's Initial Assessments were completed except his Self-Administration Medication assessment. The resident's Self-Administration Medication assessment questions numbered 1 through 17 were not completed. The Self-Administration Medication assessment results were not complete. The resident's Initial		**addressed.** Current/most recent office visit notes with current diagnoses and medication list requested from providers of all residents. **Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.** Current/most recent office visit notes with current diagnoses and medication list requested from providers of all residents. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** DON, ADON or designee are responsible for monitoring. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** DON, ADON or designee will obtain POS on all residents quarterly. Quality Assurance will review Quarterly collection of medication lists.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	Assessment LOC (Level of Care) scoring indicated he was independent in his Medication Management. Resident 4's current physician orders indicated no resident medication appeared on the orders. In an Interview on 5/2/24 at 12:12 PM, the Regional Nurse Specialist indicated Resident 4 self-administered his own medication. She indicated a resident's medication list should be obtained on admissions but was unaware medications needed to be entered as orders for resident's who self-administer medications. The Regional Nurse Specialist indicated no medication orders were available for Resident 4 and she would check on the computer. She indicated the floor nursing staff did not have access to files on the computer. A current policy titled, "Medication Administration Policy & Procedures", undated, provided by the Regional Nurse Specialist on 5/2/24 at 12:01 PM, indicated if the Community provided medication administration the Community's medication policies and procedures would be approved by a physician ...and addressed self-administration of medication. No other policy for documentation of resident's medication(s) in medication orders or physician orders was provided by the facility by survey exit.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained. 66 of 66 residents residing in the facility ate food prepared in the kitchen. Findings include: During an observation and interview on 4/30/24 at 9:05 AM, two open, unlabeled, undated bags of cereal were observed in the dry storage area of the kitchen. Cook 8 indicated she was unable to find a label and date on the cereal bags. A bag of baking cocoa was observed on a shelf open and unsealed. Cook 8 indicated products should never be left open with the product exposed. 2 open undated containers of ice cream were observed in the walk-in freezer. The Director of Dining Services indicated the ice cream belonged to the activity staff and should have been dated when opened. An undated, unlabeled tray of 21 lidded individual plastic cups with creamy textured food substances was observed in the reach in cooler. The Director of Dining Services indicated the cups contained individual servings of salad dressings. The Director of Dining Services indicated the staff did not routinely label and date the salad dressing cups. An ice machine was observed in the kitchen. The ice machine had an ice scoop container affixed to the front of the machine and contained an ice scoop. A trash can was observed positioned next to the ice machine, about 5 inches from the machine. Red- and cream-colored streaks and drops in a splatter pattern, too many to count, were observed on the side of the ice machine adjacent to the trash can, on the front of the ice machine and scoop holder. The Director of Dining Services indicated the trash can should	R 0273	**Please indicate what actions the facility had taken to ensure residents affected were addressed.** /p> **Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.**The ice scoop and trash receptacle have been relocated and the team educated on this event. The Dining Services Director will do bi-weekly checks of all items and in-service education will be provided to dining staff within 30 days regarding proper food documentation and storage. The Dining Services Director will use the community's monthly cleaning schedule and stay current on the kitchen's monthly cleaning list. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** DSD is responsible for monitoring. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?**	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	not be stored near the ice machine due to possible contamination of the ice supply. A current policy titled Food Storage Policy and Procedures, undated, provided by the Regional Operations Specialist indicated the Food Service Director or Designee should inspect and ensure all opened foods are properly dated and stored daily. The policy indicated all stored products should be labeled with the name of the food, date of storage, use by date, time of storage and employee initial. A current policy titled Cleaning Rotation Policy and Procedures, undated, provided by the Director of Dining Services indicated ice machines should be cleaned monthly.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview, and record review the facility failed to ensure pharmacy reviews were completed every 60 days for 4 of 5 residents reviewed (Resident 3, Resident 5, Resident 2, and Resident	R 0298	**Please indicate what actions the facility had taken to ensure residents affected were addressed.**The community will	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	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 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		continue to follow policy and make sure pharmacy is sending consult at least every 60 days per policy. Community will also make sure pharmacy documentation is fully provided timely. This is to take effect immediately. **Please indicate the actions the facility has taken to ensure no other 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 process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** Pharmacy will send pharmacy consultation every 60 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	survey exit. 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 6 was admitted on 5/29/21. The resident's last Consultant Pharmacist's Medication Regimen Review was dated 8/2/23. Pharmacy reviews due October, Decmber, and February for Resident 6 were not 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 pharmacy reviews should be completed at least every 60 days for each resident. A currrent policy titled, " Pharmacist Clinical Consulting Services Policy and Procedure", undated, provided by the Regional Nurse Specialist on 5/2/24 at 1:04 PM, indicated resident charts were to be reviewed every sixty days in Assisted Living faciities.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review the facility failed to ensure documentation of a physical	R 0349	**Please indicate what actions the facility had taken to ensure**	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	assessment was completed after an abuse allegation for 1 of 3 residents reviewed (Resident 5). Findings include: 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. In an employee witness statement provided by the Operations Specialist on 5/1/24 at 10:38 AM, on 4/28/24 at about 6:00 PM, Certified Nurse Aid 4 indicated she was assisting Resident 5 out of a female resident's bathroom he had wandered into when he became combative and sat in a chair. She indicated the husband of the resident residing in the room hit Resident 5 on the shoulder and pushed him as he exited the room. 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. A document titled Resident Health Assessment Skin following the incident dated 5/1/24, 3 days after the date of the incident, provided by the Administrator on 5/1/24 at 2:10 PM indicated no bruising or injury was observed upon assessment of Resident 5. No resident observations or		**residents affected were addressed.**The community has educated staff by in-servicing on the documentation process and the importance of completing documentation in a timely manner. Starting 5/15/2024 and on-going until 100% of staff have completed this in-service. The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/15/2024 regarding Cedarhurst communication expectation policy and procedures and Indiana State Department of Health long term care abuse and incident reporting policy to include any event or suspected event that occurs in the community will be reported to the ED and DON immediately so an investigation can be completed as per Cedarhurst policy and State regulations. **Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.**The community has educated staff by in-servicing on the documentation process and the importance of completing documentation in a timely manner. Starting 5/15/2024 and on-going until 100% of staff have completed this in-service. The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/15/2024 regarding Cedarhurst	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	progress notes from 4/28/24 to 4/30/24 regarding assessment of Resident 5's physical and emotional well-being were available for review. A review of vital sign records from 4/24/24 to 5/1/24, provided by the Administrator on 5/1/24 at 2:10 PM, indicated vital signs were checked on 4/26/24 at 10:41 AM, 2 days prior to the date of the incident. No other documented vital signs were available for review. In an interview on 5/1/24 at 10:38 AM, the Operations Specialist indicated she was not aware of any assessments being done to ensure the physical and emotional well-being immediately following the alleged incident on 4/28/24. A current policy titled Abuse, Neglect, and Exploitation Prevention, Prohibition, and Investigation Policy and Procedures, dated 3/14/22, provided by the Regional Director of Operations indicated upon an abuse allegation, staff should determine if the resident is safe and should determine if the resident needed any medical treatment or supportive services. The policy indicated staff should complete an incident report and document a critical note.		communication expectation policy and procedures and Indiana State Department of Health long term care abuse and incident reporting policy to include any event or suspected event that occurs in the community will be reported to the ED and DON immediately so an investigation can be completed as per Cedarhurst policy and State regulations. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** The Executive Director and DON are responsible for sustained compliance. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** The Executive Director and DON are responsible for sustained compliance. Residents will be discussed at the weekly ROAR meeting. This will help with early identification of residents at risk and trigger the necessary follow-up measures which could include meetings with families, notifications to physicians, investigations, and incident reporting if warranted. This meeting will be held weekly by the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(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 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review the facility failed to ensure accurate documentation of the resident's condition preceding death and the disposition of personal belongings for 1 of 2 residents reviewed (Resident B). Findings include: An anonymous complaint to the Indiana Department of Health indicated there was a concern about the end-of-life care provided to Resident B. Resident B's record was reviewed on 5/1/24 at 10:52 AM. Diagnoses included chronic respiratory failure, high blood pressure and heart disease. A progress note dated 12/5/23 at 10:45 PM	R 0357	Please indicate what actions the facility had taken to ensure residents affected were addressed. The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/15/2024 regarding documentation and communication expectations policy and procedure. Staff have begun in-service on 5/15/2024 regarding documentation and communication expectations policy and procedur Staff will continue documenting progress notes on resident until resident remains are picked up. This is to take effect immediately Please	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident B was actively dieing. A progress note dated 12/6/23 at 8:00 PM indicated Resident B had passed away on 12/6/23 at 5:20 PM with family at bedside. Resident B's remains had been released at or around 7:30 PM. Resident B's hospice provider and physician were notified. In an interview on 5/2/24 at 10:35 AM the Regional Nurse Specialist indicated they were not familiar with Indiana death documentation requirements. The Regional Nurse Specialist indicated the facility did not use a form for the release of resident remains. The Regional Nurse Specialist indicated the facility did not document the release of personal belongings. A current facility policy dated 9/26/22 provided by the Regional Nurse Specialist on 5/2/24 at 12:02 PM indicated all the deceased resident's records should be placed in the resident's file. This citation relates to Complaint IN00431428.		indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice. The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/15/2024 regarding documentation and communication expectations policy and procedure. Staff have begun in-service on 5/15/2024 regarding documentation and communication expectations policy and procedure.Staff will continue documenting progress notes on resident until resident remains are picked up. This is to take effect immediately. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** The DON will be responsible for monitoring. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** Residents will be discussed at the weekly ROAR meeting. This will help with early identification of residents at risk and trigger the necessary follow-up measures which could include meetings with families, notifications to physicians,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
			investigations, and incident reporting if warranted. This meeting will be held weekly 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 is completed. Monitoring will be ongoing.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview the facility failed to ensure the infection control program analyzed patterns, tracked, trended infections, and ensured antibiotic stewardship. 66 residents resided in the facility. Findings include: A current undated policy titled, "Infection Control (General) Policy & Procedures", provided by the Regional Nurse Specialist on 5/1/24 at 10:40 AM, indicated staff would comply with infection control practices that prevent or minimize the	R 0407	**Please indicate what actions the facility had taken to ensure residents affected were addressed.** /p> **Please indicate the actions the facility has taken to ensure no other 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.	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	spread of infection and comply with CDC (Center of Disease Control and Prevention) guidelines. No infection control program to analyze patterns, track ongoing trends of infectious symptoms and antibiotic stewardship in the facility was located in the policy. A current policy titled, "Infectious Disease Outbreak Policy & Procedures", updated 8/1/22, provided by the Regional Nurse Specialist on 5/1/24 at 10:40 AM, indicated CDC guidelines would be reviewed to prevent the spread of infection when the Community is experienced an outbreak and staff will adhere to sound infection control practices. No infection control program to analyze patterns, track ongoing trends of infectious symptoms and antibiotic stewardship in the facility was located in the policy. A current policy titled, "Universal/Standard Precaution Policy & Procedures", undated, provided by the Regional Nurse Specialist on 5/1/24 at 10:40 AM, provided no infection control program information to analyze patterns, track ongoing trends of infectious symptoms and antibiotic stewardship in the facility. A current policy titled, "Alert Charting Policy & Procedures", updated 5/2/24, provided by the Regional Nurse Specialist on 5/2/24 at 12:01 PM, indicated alert charting would be completed for resident's with infections and/or new medications. The policy indicated residents placed on alert charting would be evaluated and documentation completed for 72 hours or until the Director of Wellness or Licensed Nurse discontinues the alert charting. No infection control program to analyze patterns, track ongoing trends of infectious symptoms and antibiotic stewardship in the facility was located in the policy.		Tracking will provide the ability to trend infections and treatments going forward. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** DON is responsible for monitoring. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not recur. How often will the Quality Assurance program review monitoring and for what length of time?** DON, ADON, or designee will update and maintain the infection log as well as follow up with providers as needed for further treatments. This will be ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 5/2/24 at 12:12 PM, the Regional Nurse Specialist indicated the facility should have a policy on tracking, trending of infections and antibiotic use.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, 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 failed to ensure current annual health statements were completed and current for 4 of 5 residents reviewed (Resident 3, Resident 5 and Resident 2 and Resident 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. A Document titled Physician's Assessment, History and Physical and Certification dated 5/25/23 included a health statement section to indicate whether Resident 3 was free of communicable disease. The section was not completed on the form. No other documents containing a statement of freedom from communicable disease for Resident 3 were available for review.	R 0409	**Please indicate what actions the facility had taken to ensure residents affected were addressed.** ="" span **Please indicate the actions the facility has taken to ensure no other residents were affected by the alleged deficient practice.** Updated Physician Certifications have been requested from resident's PCP. **Please indicate who is responsible, the duration and frequency of monitoring to prevent recurrence.** DON, ADON, or designee will monitor paperwork on incoming residents as well as updated documentation as needed on an ongoing basis. **Please explain the role the facility quality assurance program will have in the on-going monitoring process to ensure this deficiency does not**	11/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	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. A Document titled Physician's Assessment, 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. No document containing a primary care provider's (PCP) statement to indicate Resident 2 was free from infectious/communicable diseases was provided by the facility for review by survey exit.		**recur. How often will the Quality Assurance program review monitoring and for what length of time?** DON/DOS will be responsible for monitoring. This will be on-going for all new move-ins.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 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 physician orders contained no order to indicate the resident was free from infectious/communicable diseases. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF FORT WAYNE	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 DEFICIENCY)	(X5) COMPLETION DATE
	physician within 120 days prior to moving into the facility and on an annual basis with the Physicians Assessment, History and Physical, & certification form. No other policy for completion of annual health statements by a primary care provider was provided by the facility by survey exit.			