PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155828	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/06/2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD  5250 HERITAGE PARKWAY  FORT WAYNE, IN 46835				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
F 0000							
Bldg. 00	This visit was for Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.  Survey dates: February 29, March 1, 4, 5 and 6, 2024  Facility number: 012931 Provider number: 155828 AIM number: 201278730  Census Bed Type: SNF/NF: 47 SNF: 7 Residential: 17 Total: 71  Census Payor Type: Medicare: 6 Medicaid: 17 Other: 31 Total: 54  This deficiency reflects state findings cited in		F 00	000			
	accordance 410 IAC	C 16.2-3.1  pleted March 8, 2024					
F 0812 SS=F Bldg. 00	§483.60(i) Food sa The facility must - §483.60(i)(1) - Pro	e/Prepare/Serve-Sanitary afety requirements.  cure food from sources dered satisfactory by cal authorities.					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE

Edwin T. Rice Administrator 04/04/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AHYH11 Facility ID: 012931 If continuation sheet Page 1 of 6

PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155828		B. WING 03/06/202			/2024		
NAME OF P	PROVIDER OR SUPPLIER	<u>.                                    </u>			ADDRESS, CITY, STATE, ZIP COD		
HERITAGE POINTE OF FORT WAYNE					ERITAGE PARKWAY WAYNE, IN 46835		
(X4) ID	Г			ID	 		(Y5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		,	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	ì ·	R LSC IDENTIFYING INFORMATION	'	TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	DATE
1110		de food items obtained		11.13			2.112
	`'	producers, subject to					
	applicable State a						
	regulations.						
		does not prohibit or prevent					1
		g produce grown in facility					
		o compliance with					
		owing and food-handling					
	practices.	<b>.</b>					
	(iii) This provision	does not preclude residents					
	from consuming for	oods not procured by the					
	facility.						
	§483.60(i)(2) - Store, prepare, distribute and						
		ordance with professional					
	standards for food	l service safety.					
			F 08	12	This Plan of Correction consti		03/07/2024
		on, interview, and record			the facility's written allegation	of	
	review the facility failed to ensure opened items				compliance for the deficiency	- <b>£</b>	
	were dated, labeled and baking pans were				cited. Submission of this Plan		
	thoroughly dried prior to storage in the facility				Correction is not an admission		
	kitchen. 54 of 54 residents residing in the facility				that a deficiency exists or that		
	consumed food prepared in the kitchen.				was cited correctly. This Plan Correction is submitted to mee		
	Findings include:				requirements established by s		
					and federal laws.	olale	
	During an observation and interview on 2/29/24 at				and lodoral lavvs.		
	9:18 AM, a bag of tilapia fillets on a shelf inside				How the corrective action will	be	
	the walk- in freezer had been opened and was				accomplished for identified		
	sealed shut with a Ziploc style closure. The bag				affected individuals?		
	was not marked with the date on which it was				All currently opened items in t	he	1
	opened. The Direct	tor of Dining Services (DDS)			facility kitchen have been		
	indicated the bag should have been labeled with				reviewed, dated, and labeled	as of	
	an open date. A metal container filled with french				02/29/2024. All baking pans h		
	fries, covered loosely with a piece of plastic wrap				been re-washed, thoroughly d		
	was observed on the shelf of the walk-in cooler.				and properly stored to prevent	t	
	The DDS indicated he was unable to find a date				contamination as of 02/29/202	24.	
	indicating when the container was filled and				All kitchen staff have been		
	prepared. A plastic container containing				re-educated on the use of		
cupcakes was observed on the shelf in the freezer.				improperly labeled, dated, and	t		

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

Event ID:

AHYH11 Facility ID: 012931

If continuation sheet Page 2 of 6

PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 03/06/2024 155828 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5250 HERITAGE PARKWAY HERITAGE POINTE OF FORT WAYNE FORT WAYNE. IN 46835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The sticker that had sealed the package was torn. stored items and equipment as of There were 2 cupcakes and 2 open spots in the 3/13/2024. container with smears of red frosting. The DDS How will other individuals with the indicated the cupcakes should have been labeled potential to be affected be and dated. identified and protected? 54 out of 54 SNF residents During an observation and interview on 2/29/24 at potentially affected by deficiency 9:32 AM Chef 3 separated 4 baking sheets. Upon determined on 3/7/2024 by HFA. separation, liquid present on the pans dripped to What measures will be put into the floor. Chef 3 indicated the baking sheets place or systemic changes made should have been air dried prior to stacking and to ensure the deficient practice will storing. not recur? By 03/13/2024, mandatory training During an interview on 3/1/24 at 12:04 PM, the sessions for all kitchen staff on DSS indicated all 54 residents in the nursing proper food labeling, dating of facility consumed food prepared in the kitchen. opened items, and drying and storage procedures for kitchen A current policy titled Freezer Storage Life of equipment. Foods dated January 2023 provided by the DDS at How will the facility plan to monitor 12:39 PM on 3/1/24 indicated when a case of food its performance to make sure was partially used and the remaining food was solutions are sustained? exposed to the air, the remaining food should be Kitchen F812 audit established. relabeled as opened and used within 3 months. Director of Dining Services (DDS), or designee, conducts weekly A current policy titled Sanitation and Infection checks for six months to verify Prevention/Control dated January 2023 provided compliance with labeling, dating, by the DDS at 12:39 PM on 3/1/24 indicated all and equipment drying/storage food contact surfaces including pots, and dishes procedures. Weekly checks should be air dried and not stacked when wet. reported to HFA and QA committee. Should 100% 3.1-21(i)(2)compliance not be achieved during 3.1-21(i)(3)six months, QA committee will recommend additional compliance strategies. Corrective actions to address these deficiencies took place immediately following the surveyor's initial observations in our Kitchen on 03/01/2024. All items in the freezer were correctly

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

PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  155828	A. BUILDING B. WING	00	COMPLETED 03/06/2024		
NAME OF PROVIDER OF SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5250 HERITAGE PARKWAY				
HERITAC	SE POINTE OF FOR	RT WAYNE	FORT	WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  TAG  DEFICIENCY)			
				labeled and re-stored, all store pots and pans were inspected re-washed as required, air-drie and stored inverted on the storack.	, ed,		
R 0000							
Bldg. 00			R 0000				
		State Residential Licensure ncluded a Recertification and vey.					
	Survey dates: Febru 2024	ary 29, March 1, 4, 5 and 6,					
	Facility number: 012	2931					
	Residential Census:	17					
	This State Residenti accordance with 410	al Finding is cited in IAC 16.2-5.					
	Quality reivew com	pleted March 8, 2024					
R 0273	410 IAC 16.2-5-5.						
Bldg. 00	(f) All food prepara (excluding areas in maintained in acco	nal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and id safe food handling ing 410 IAC 7-24.					
	review the facility fa were dated and labe thoroughly dried pri	on, interview, and record ailed to ensure opened items led and baking pans were or to storage in the facility sidents residing in the facility	R 0273	This Plan of Correction constit the facility's written allegation compliance for the deficiency cited. Submission of this Plan Correction is not an admission that a deficiency exists or that	of of		

State Form Event ID: AHYH11 Facility ID: 012931 If continuation sheet Page 4 of 6

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

PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155828		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/06/2024			
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD			
HERITAGE POINTE OF FORT WAYNE			5250 HERITAGE PARKWAY FORT WAYNE, IN 46835				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	consumed food prep	pared in the kitchen.		was cited correctly. This Plan	• • • • • • • • • • • • • • • • • • •		
	Findings include:			Correction is submitted to me requirements established by			
	During on observati	on and interview on 2/20/24 at		and federal laws.			
	_	on and interview on 2/29/24 at ilapia fillets on a shelf inside		How the corrective action will	he		
		had been opened and was		accomplished for identified	DC		
		Liploc style closure. The bag		affected individuals?			
		h the date on which it was		All currently opened items in	the		
	opened. The Direct	or of Dining Services (DDS)		facility kitchen have been			
	indicated the bag should have been labeled with			reviewed, dated, and labeled	as of		
	an open date.			02/29/2024. All baking pans h	nave		
				been re-washed, thoroughly	dried,		
	A metal container filled with french fries, covered			and properly stored to prever			
	loosely with a piece of plastic wrap was observed			contamination as of 02/29/20	24.		
	on the shelf of the walk-in cooler. The DDS			All kitchen staff have been			
	indicated he was unable to find a date indicating			re-educated on the use of			
	when the container was filled and prepared.			improperly labeled, dated, an			
	Δ plastic container	containing cupcakes was		stored items and equipment a 3/13/2024.	as oi		
	_	of the freezer. The sticker		How will other individuals with	n the		
	that had sealed the package was torn and there			potential to be affected be	1 110		
	were 2 cupcakes and 2 open spots in the container			identified and protected?			
	with smears of red frosting. The DDS indicated			17 out of 17 AL residents			
	the cupcakes should have been labeled and dated.			potentially affected by deficie	ncy		
				determined on 3/7/2024 by H	FA.		
	During and observation and interview on 2/29/24			What measures will be put in	to		
	at 9:32 AM Chef 3 separated 4 baking sheets.			place or systemic changes m			
	Upon separation, liquid present on the pans			to ensure the deficient praction	ce will		
	dripped to the floor. Chef 3 indicated the baking			not recur?			
sheets should have been air dried prior to			By 03/13/2024, mandatory training				
	stacking and storing.			sessions for all kitchen staff of			
	Duning on intermitation 2/1/24 -4 12 04 DM /			proper food labeling, dating of			
	During an interview on 3/1/24 at 12:04 PM, the			opened items, and drying and			
	DSS indicated 17 residents in the residential facility consumed food prepared in the kitchen.			storage procedures for kitche equipment.	911		
				How will the facility plan to m	onitor		
	A current policy titl	ed Freezer Storage Life of		its performance to make sure			
	A current policy titled Freezer Storage Life of Foods dated January 2023 provided by the DDS at			solutions are sustained?			
	12:39 PM on 3/1/24 indicated when a case of food			Kitchen R273 audit establishe	ed.		

State Form Event ID: AHYH11 Facility ID: 012931 If continuation sheet Page 5 of 6

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

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
155828			B. WING		03/06/2024			
NAME OF PROVIDER OR SUPPLIER  HERITAGE POINTE OF FORT WAYNE			5250 H	STREET ADDRESS, CITY, STATE, ZIP COD 5250 HERITAGE PARKWAY FORT WAYNE, IN 46835				
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	ID	1	(X5)			
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION			
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
		and the remaining food was	1110	Director of Dining Services (D				
		the remaining food should be		or designee, conducts weekly	, .			
		I and used within 3 months.		checks for six months to verify				
				compliance with labeling, dati				
	A current policy tit	led Sanitation and Infection		and equipment drying/storage	-			
		dated January 2023 provided		procedures. Weekly checks				
		9 PM on 3/1/24 indicated all		reported to HFA and QA				
	food contact surfac	es including pots, and dishes		committee. Should 100%				
	should be air dried	and not stacked when wet.		compliance not be achieved d	uring			
				six months, QA committee wil	ı -			
				recommend additional complia	ance			
				strategies.				
				Corrective actions to address				
				these deficiencies took place				
				immediately following the				
				surveyor's initial observations	in			
				our kitchen on 03/01/2024. A	II			
				items in the freezer were corre	ectly			
				labeled and re-stored, all store	ed			
				pots and pans were inspected	l,			
				re-washed as required, air-dri	ed,			
				and stored inverted on the sto	rage			
				rack.				
				=""  i="">				
				="" liall="" staff="" re-educated	d=""			
				on="" use="" improperly=""				
				labeled,="" equipment="" 3=""				
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State Form Event ID: AHYH11 Facility ID: 012931 If continuation sheet Page 6 of 6