STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155828	A. BUILDING 00 B. WING	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF FORT WAYNE	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Healthcare Complaints IN00451501 and IN00451713. Complaint IN00451501-No deficiencies realted to the allegations are cited Complaint IN00451713-No deficiencies realted to the allegations are cited Survey dates: February 4, 5, 6, 7 and 10, 2024. Facility number: 012931 Provider number: 155828 AIM number: 201278730 Census Bed Type: SNF/NF: 30 SNF: 25 Residential: 21 Total: 55 Census Payor Type: Medicare: 4 Medicaid: 20 Other: 31 Total: 55 These deficiencies reflect state findings cited in accordance 410 IAC 16.2-3.1 Quality review completed February 11, 2025	F 0000		
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rod Craft	Executive Director	02/21/2025

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.

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Bldg. 00		F 0880	/p> **/b>** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** **The facility has implemented comprehensive measures to ensure proper use of personal protective equipment (PPE) among staff:** **1. Re-education on donning and doffing procedures: All staff members have been re-trained on the correct methods for putting on (donning) and removing (doffing) PPE according to CDC guidelines (see attachment #1).** **2. Visual aids at PPE stations: The Executive Director/Director of Nursing has ensured that visual aids are posted at designated PPE stations (see attachment #2). These aids serve as quick reference guides, reinforcing correct practices and helping staff members remember the proper sequence for donning and doffing PPE.** ***How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken.*** **The facility has recognized that deficient infection control**	02/23/2025

Based on observation, interview, and record review the facility failed to ensure enhanced barrier precautions were maintained for 1 of 1 resident reviewed related to infection control (Resident 158).

Findings include:

During an observation, on 2/4/25 at 2:11 PM, Resident 158's door was closed and had a large rack containing bags of isolation gowns, N-95 masks, and boxes of gloves hanging on the outside of the door. Signage was posted on the door indicating the room was in isolation, provided instructions for application of gowns, gloves and N-95 masks.

During an observation, on 2/4/25 at 2:18 PM, Certified Nurse Aide (CNA) 2 approached the door to Resident 158's room, applied a gown, surgical mask and gloves, knocked on the door, entered the room and approached Resident 158.

According to CDC face mask guidelines, dated March 1, 2024, surgical masks are not appropriate for protection from the COVID 19 infection.

Resident 158's record was reviewed on 2/4/25 at 12:45 PM. Diagnoses included COVID-19 infection and chronic systolic heart failure.

Resident 158's current admission Minimum Data Set (MDS) dated 1/28/25 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact).

Resident 158's current care plan titled I require isolation ... indicated the resident had a positive

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HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

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	COVID-19 diagnosis, with a goal date of 2/17/25. Interventions included using transmission based (droplet) isolation precautions. Physician orders dated 2/4/25 indicated transmission- based precautions including an N-95 mask were required to enter the room. In an interview, on 2/4/25 at 2:22 PM, the Assistant Director of Nursing indicated all employees entering a COVID positive room must wear an N-95 mask. A current policy, titled COVID-19 Infection Prevention and Control, dated 3/28/20, provided by the Assistant Director of Nursing on 2/7/25 at 11:11 AM, indicated residents testing positive for COVID-19 require the use of proper personal protective equipment including N-95 masks if available. 3.1-18(a)		**practices could potentially impact all residents. In response, a comprehensive review of the infection control policy was conducted. This review specifically focused on ensuring that the policy includes clear, step-by-step instructions for both donning (putting on) and doffing (removing) personal protective equipment (PPE).** ***What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.*** The community will train staff on standard and transmission-based precautions to improve infection control for any new cases. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place.*** To ensure compliance, a "Donning and Doffing Personal Protective Equipment Audit (attachment #3) will be conducted according to the following schedule:	

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			- Weekly for the first 4 weeks - Monthly for the next 4 months - Quarterly for 6 months thereafter All audit results will be shared with the Quality Assurance and Performance Improvement (QAPI) team for continuous monitoring and improvement ***By what date the systemic changes for each deficiency will be completed.*** February 23rd	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Healthcare Complaints IN00451501 and IN00451713. Survey dates: February 4, 5, 6, 7 and 10, 2024 Facility number: 012931 Residential Census: 21 Heritage Pointe of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000		

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