PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES					
	CENTERS FOR MEDICARE & MEDI	CAID SERVICES			
ı	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155828		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/12/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5250 HERITAGE PARKWAY FORT WAYNE, IN 46835					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
F 0000								
Bldg. 00	This visit was for the Investigation of Complaint IN00447537. Complaint IN00447537 - Federal/state deficiencies related to the allegations are cited at F609 and F610. Survey date: December 12, 2024		F 00	000				
	Facility number: 012 Provider number: 15 AIM number: 20127 Census Bed Type: SNF/NF: 31 SNF: 25 Total: 56	55828						
	accordance with 410	eflect State Findings cited in						
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations							
	failed to ensure an a	and record review, the facility llegation of physical abuse f 3 residents reviewed for	F 0609		Heritage Pointe of Fort Wayne seeking a desk review, as outl in the attached letter. This Plan of Correction constit	ined	12/30/2024	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				3	TITLE		(X6) DATE	

Rod Craft Executive Director 12/30/2024

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			ľ	JILDING		COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			00			
155828			B. WING 12/12/2024					
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
					ERITAGE PARKWAY			
HERITAC	GE POINTE OF FO	RT WAYNE		FORT V	WAYNE, IN 46835			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
	Findings include:				the facility's written allegation	of		
					compliance for the deficiency			
		nplaint reported to the Indiana			sited. Submission of this Plar	n of		
	_	lth, dated 11/15/24, alleged on			Correction is not an admission	า		
		B had reported to her family, a			that a deficiency exists or that	one		
	Certified Nurse Aid	de (CNA 3) had been rough			was cited correctly. This Plan	of		
	while providing inc	continent care. The resident			Correction is submitted to me	et		
	alleged she slapped	CNA 3 to stop hurting her			requirements established by s	state		
	and the CNA slappe	ed her back. Resident B			and federal laws.			
	slapped the CNA a	second time and CNA 3			What corrective action(s) will	be		
slapped the resident back a se		t back a second time. The			accomplished for those reside	ents		
incident had been reported to the Director of Nursing (DON) but the complainant alleged then had been no follow up to the reported altercation		eported to the Director of			found to have been affected b	y		
		t the complainant alleged there			the deficient practice.			
		up to the reported altercation.			The Director of Nursing condu	ıcted		
					a comprehensive investigation	n into		
	On 12/12/24 at 11:1	15 A.M., Resident B's record			the alleged incident, which			
	was reviewed. Diag	gnoses included recurrent			involved obtaining statements	from		
	urinary tract infecti	ons (UTI), dementia, and			relevant staff members, perfo	rming		
	cerebral atheroscler	rosis (Arteries in the brain			a thorough skin assessment of	of the		
	become hard, thick,	, and narrow due to buildup of			resident, and reviewing video			
	plaque inside the ar	rtery walls).			footage related to the event. I	n		
					response to the situation,			
	A significant chang	ge in condition Minimum Data			immediate actions were taken	to		
	Set (MDS) assessm	nent, dated 10/12/24, indicated			ensure the safety and well-be	ing of		
	the resident had mo	derately impaired cognition			the resident. These measure	s		
	with no behaviors.	She required moderate			included reassigning the emp	loyee		
	assistance to being	dependent with all activities			allegedly involved in the incide	ent to		
	of daily living (AD	L).			a different area of the campus	and		
					implementing a "Care in Pairs	."		
		ote, dated 11/11/24 at 8:06 a.m.,			approach to provide enhance	d		
		ent had complained of			supervision for the resident. (On		
		rinating and had increased			11-15-24, the family of the res	sident		
	incontinence. She w	was observed with a			was informed about the findin	gs of		
"functional decline" and had voiced some intermittent confusion.		" and had voiced some			the investigation and the			
		ion.			interventions that had been po	ut in		
					place, including the employee			
		ote, dated 11/12/24 at 11:20			reassignment and the			
	p.m., indicated a ur	inalysis had been sent out to			implementation of the "Care in	า		
	the hospital on 11/1	11/24 and facility was waiting			Pairs" protocol. Additionally,	the		
	on results.				facility reported the incident to			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 12/12/2024 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 gateway on 12-24-24 There was no documentation or follow-up completed in the resident's record regarding the How other residents having the resident's allegation of being slapped by CNA 3 potential to be affected by the the morning of 11/12/24. same deficient practice will be identified and what correction On 12/12/24 at 1:25 P.M., the DON was action(s) will be taken. interviewed. She indicated she had spoken with A comprehensive review of all both family members on the phone on 11/12/24, incident reports from the past year and had initiated an investigation but had not was undertaken to address the reported the incident as required for an allegation potential impact of the deficient of abuse. practice on all residents. This thorough examination aimed to On 12/12/24 at 3:09 P.M., Resident B's family identify any instances of member was interviewed. The family member underreporting or inadequate indicated, the morning of 11/12/24, she had been investigations, ensuring that every in to visit the resident, who reported to her, CNA incident had been properly 3 had been rough with her and slapped her twice. scrutinized and handled in The family member indicated she was told of this accordance with the facility's and told another family member who immediately established policies and reported to the DON. At the time of the allegation, procedures. The findings from this the family member believed the resident was extensive review will be presented cognitively aware, able to accurately describe to the Quality Assurance and what had occurred and who the CNA was. Performance Improvement (QAPI) however, the resident would not be able to team for analysis. Furthermore, describe the incident at this time due to overall these results will be incorporated decline in condition. into ongoing trend analysis and tracking processes, allowing for A current facility policy, titled "Abuse, Neglect continuous monitoring and and Exploitation", was provided on 12/12/24 at improvement of incident reporting 11:00 A.M. by the DON, which stated the and investigation practices within following:..."Physical Abuse includes, but is not the facility. limited to hitting, slapping, punching, biting, and What measure will be put into kicking...Identification of Abuse, Neglect and place and what systemic Exploitation...possible indicators of abuse include, changes will be made to ensure but are not limited to: Resident, staff or family that the deficient practice does

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report of abuse...Reporting/Response: The facility

will have written procedures that include:

Reporting of all alleged violations to the

Administrator, state agency, adult protective

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not recur.

The facility has taken decisive

steps to enhance its reporting

procedures and ensure

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
155828		B. WING 12/12/2024					
NAME OF BROWINGS OR CURBLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t		5250 H	ERITAGE PARKWAY		
HERITAC	GE POINTE OF FO	RT WAYNE		FORT \	WAYNE, IN 46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5	5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATI	E
		other required agencies within			compliance across all levels o	f	
	specified timeframe	.'s"			administration. All key		
	TELL CLASS 1	G 1 : DIOMAGE 27			administrative personnel, inclu	iding	
	This Citation relates	s to Complaint IN00447537.			the Director of Nursing,		
	2.1.29(-)				Administrator, Social Service		
	3.1-28(c)				Director, and Assistant Director	or of	
					Nursing, have successfully		
					completed mandatory training		
					Reporting Compliance (attach		
					#1). This comprehensive train reinforces the importance of p	-	
					reporting protocols. Looking	ohei	
					ahead, the facility plans to		
					implement a user-friendly		
					electronic system designed to		
					streamline the reporting proce	99	
					for all staff members. This upg		
					aims to simplify and standardi		
					incident reporting, making it m		
					efficient and accessible for		
					employees at all levels.		
					How the corrective action(s)	will	
					be monitored to ensure the		
					deficient practice will not		
					recure, i.e., what quality		
					assurance program will be p	ut	
					into place.		
					The Abuse Investigation Aud	t	
					Form and the F-609 Audit Too	ı [
					(attachment #2) have been		
					implemented to ensure		
					compliance and effectiveness		
					reporting and investigating alle	-	
					violations. Here is the schedul	e for	
					conducting these audits:		
					Weekly Audits: The audit will I		
					conducted once a week for the		
					first 4 weeks.		
					Monthly Audits: Following the		
			1		initial 4 weeks, the audit will b	e	

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	Γ OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB 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 12/12/2024		
	PROVIDER OR SUPPLIE			5250 H	ADDRESS, CITY, STATE, ZIP COD IERITAGE PARKWAY WAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					conducted once a month for the next 4 months. Quarterly Audits: After the monthly audits, the audit will be conducted once a quarter for 6 months. All results from these audits we be shared with the Quality Assurance and Performance Improvement (QAPI) team to ensure continuous monitoring improvement. By what date the systemic changes for each deficiency be completed. December 30th	e 6 ill and	
F 0610 SS=D Bldg. 00	Based on interview failed to ensure a talleged physical alteristical residents reviewed. Findings include: An anonymous condition Department of Head 11/12/24, Resident Certified Nurse Air	ent/Correct Alleged Violation of and record review, the facility thorough investigation of couse was conducted for 1 of 3 for abuse (Resident B). Implaint, reported to the Indiana alth, dated 11/15/24, alleged on the B had reported to her family, a de (CNA 3) had been rough continent care. The resident	F 00	510	F-610 What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice. The administration conducted thorough review of the investig concerning resident B, specific focusing on identifying any inadequacies or failures to add to the company's established	a gation cally	12/30/2024

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alleged she slapped CNA 3 to stop hurting her

slappeded her back a second time. The incident

(DON) but the complainant alleged there had been

and the CNA slapped her back. Resident B

slapped the CNA a second time and CNA 3

had been reported to the Director of Nursing

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policies regarding abuse

investigations. Following the

analyzed and subsequently

review, the findings were carefully

shared with the Quality Assurance

and Performance Improvement

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SI	URVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	<u>00</u> co		COMPLETED	
AND PLAN OF CORRECTION		155828	B. W	ING			2/12/2024	
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD	1		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ERITAGE PARKWAY			
HERITAG	GE POINTE OF FO	RT WAYNE			WAYNE, IN 46835			
	T				T	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
	no follow up to the	reported altercation.			(QAPI) team. As a proactive			
	On 12/12/24 at 11:1	15 A.M. Dagidant Dia second			measure resulting from this re			
		15 A.M., Resident B's record gnoses included recurrent			the facility has implemented a			
		ons (UTI), dementia, and			"Allegation of Abuse/Neglect			
		ons (O11), dementia, and osis (Arteries in the brain			Checklist" (attachment #3). T			
		, and narrow due to buildup of			tool to guide staff through the			
	plaque inside the ar	_			proper procedures when	·		
	Plaque miside me ai	wans).			addressing potential incident	s of		
	A significant change	e in condition Minimum Data			abuse or neglect.	3 01		
		ent, dated 10/12/24, indicated			How other residents having	n the		
	the resident had moderately impaired cognition with no behaviors. She required moderate				potential to be affected by t			
					same deficient practice will			
		dependent with all activities			identified and what correcti			
	of daily living (AD)				action(s) will be taken.			
	,	,			A comprehensive review of a	all		
	A care plan, revised	1 11/25/24, indicated the			incident reports from the pas			
	-	y with episodes of agitation			was undertaken to address the	-		
	·	during care. Interventions			potential impact of the deficie			
		d and yelling at others, offer 1:1			practice on all residents. This			
		assurance, explain the			thorough examination aimed			
	behavior wasn't app	propriate and ask to			identify any instances of			
	stop-initiated 11/25/24.				underreporting or inadequate	,		
					investigations, ensuring that	every		
	* '	d on 12/3/23, indicated the			incident had been properly			
		r and bowel incontinence.			scrutinized and handled in			
		led: Offer care in pairs-initiated			accordance with the facility's			
	11/15/24.				established policies and			
					procedures. The findings fror			
		ote, dated 11/11/24 at 8:06 a.m.,			extensive review will be pres			
		nt had complained of			to the Quality Assurance and			
		rinating and had increased			Performance Improvement (0	· · · · · · · · · · · · · · · · · · ·		
	incontinence. She w				team for analysis. Furthermo			
		" and had voiced some			these results will be incorpora			
	intermittent confusi	ion.			into ongoing trend analysis a			
	,	. 1 . 111/12/24 . 11 20			tracking processes, allowing	for		
		ote, dated 11/12/24 at 11:20			continuous monitoring and			
	*	inalysis had been sent out to			improvement of investigation			
	-	1/24 and facility was waiting			practices within the facility.			
on results.					What measure will be put in	nto		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155828		IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		B. Wl	ING		12/12	/2024	
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
LIEDITA	05 DOINTE 05 50	DT MANALE			ERITAGE PARKWAY		
HERITAGE POINTE OF FORT WAYNE				FORT	WAYNE, IN 46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					place and what systemic		
	There was no docur	mentation or follow-up			changes will be made to ens	ure	
	completed in the Re	esident B's record regarding the			that the deficient practice do		
	resident's allegation	of being slapped by CNA 3			not recur.		
	the morning of 11/1				Staff members will undergo		
					mandatory training on abuse		
	On 12/12/24 at 1:25	5 P.M., the DON was			investigation protocol, including	ıq	
	interviewed. She in	dicated, on 11/12/24, she had			suspension of alleged staff	3	
		members on the phone. They			members until completion of		
	reported an alleged altercation between Resident B and CNA 3 had occurred that morning. After speaking with family, she called and spoke with staff who had worked on night shift and the				investigation (attachment #3).		
					How the corrective action(s)	will	
					be monitored to ensure the		
					deficient practice will not		
		4. On 11/12/24, she spoke with			recure, i.e., what quality		
	-	CNA 3 indicated when she went			assurance program will be p	ut	
		p for the morning, she noticed			into place.		
	-	ore agitated by the tone of her			The Abuse Investigation Audit	•	
		rouble rolling the resident in			Form and the F-610 Audit Too		
		her to put her hand on the			(attachment #4 and attachmen		
	_	h rolling. Resident B would not			#5) have been implemented to		
	-	ne side rail where placed but			ensure thorough and complian		
	_	resident or being hit by the			investigations. Here is the aud		
		dicated the resident was tearful			schedule:		
	at breakfast but had	l calmed down after talking					
	with her. The reside	ent was unable to say why she			Weekly Audits: The audit will I	ре	
	had been crying. Th	ne DON indicated, after			conducted once a week for the		
	speaking with CNA	3 by phone, she had not			first 4 weeks.		
	suspended the CNA because she had determined there was no abuse that occurred. There were no interviews conducted with other residents who were cared for by CNA 3 nor skin assessments completed on non-interviewable residents to				Monthly Audits: Following the		
					initial 4 weeks, the audit will be	е	
					conducted once a month for the		
					next 4 months.		
					Quarterly Audits: After the		
	_	f unknown source. CNA 3			monthly audits, the audit will b	е	
		k her next scheduled day			conducted once a quarter for		
		vided care to Resident B. The			months.		
		family had requested CNA 3			All results from these audits w	ill	
		the resident and was no longer			be shared with the Quality		
	_	her. When asked, the DON			Assurance and Performance		

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indicated CNA 3 should have been suspended

and not allowed to return to duty until a thorough

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Improvement (QAPI) team to

ensure continuous monitoring and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155828	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2024				
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	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE		
					improvement.				
	and Exploitation", v 11:00 A.M. by the I following:"Physic limited to hitting, sl kickingIdentificat Exploitationpossil but are not limited t report of abuseInv Neglect and Exploit investigation is war abuseare reported investigations includinterviewing all invalleged victim, alleg others who might ha allegationsProvidi documentation of th Resident: The facili all residents are pro psychosocial harm a during and after the include by are not li immediately to prot integrity of the inve alleged victim for ar physical examinatio if needed; increased victim and residents protect the resident protection from reta support and counsel revision of resident' incident of abuse This Citation relates	olicy, titled "Abuse, Neglect was provided on 12/12/24 at DON, which stated the al Abuse includes, but is not apping, punching, biting, and ion of Abuse, Neglect and ole indicators of abuse include, or Resident, staff or family restigation of Alleged Abuse, ation: An immediate ranted when suspicion of Written procedures for de: Identifying and olved persons, including the ged perpetrator, witnesses, and ave knowledge of the ang complete and thorough are investigation Protection of the will make efforts to ensure tected from physical and as well as additional abuse, investigation. Examples mitted to: Responding eet the alleged victim and stigation; examining the my sign of injury, including a m or psychosocial assessment as upervision of the alleged st; room or staffing changes to from the alleged perpetrator; liation; providing emotional ing to the resident; and s care planas a result of an			improvement. By what date the systemic changes for each deficiency be completed. December 30	will			
	3.1-28(d)		1						

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CENTERSTOR	WEDICAKE & WEDIC	AID SERVICES				ONID 110. 0750-057		
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155828	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2024			
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		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CORRECTIVE ACTION SHOULD BE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)	71L	DATE	

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