STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FORT WAYNE	9210 MAYSVILLE ROAD, FORT WAYNE, , 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 471626, 471834, and 472031. Intake 471626 - State deficiencies related to the allegations are cited at R0240 and R0247. Intake 471834 - State deficiencies related to the allegations are cited at R0240 and R0247. Intake 472031 - State deficiency related to the allegations are cited at R0216. Survey date: September 23, 24, and 25, 2026 Facility number: 014576 Residential Census: 74 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed	R 0000		

	September 28, 2026			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (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 a resident received care and services for identified safety needs related to falls and behavior of lying and sleeping on the floor for 1 of 4 residents reviewed (Resident C). Findings include: A report, dated 9/15/26, alleged Resident C had been allowed to	R 0216	R216 Evaluation and Service Planning 1. Corrective Action for Affected Resident Resident C has moved out from the community to a higher level of care. No further corrective action is applicable to this resident. 2. Identification of Other Residents The department head or designee will review residents with known falls, recurrent floor-level behaviors, or care refusals to ensure assessments and service plans accurately reflect their current needs and individualized interventions. 3. Measures to Prevent Recurrence Clinical staff will be reeducated on fall management, resident refusals, timely reassessment, documentation, and notifications for updating service plans to reflect changes in condition or behavior. 4. Monitoring for Continued Compliance The clinical department head or designee will audit residents	09/29/2026

	lie on the floor next to his bed for 2 hours prior to being assisted up off the floor. Resident C, had been observed on video, slowing falling to the floor in the middle of the night. His head was lying on the bottom shelf of his bedside stand. Certified Nurse Aid 5 (CNA), was observed at 4:18 a.m., coming into the room and seeing the resident on the floor. CNA 5 asked the resident if he had fallen and wanted picked up. Resident C, who had severely impaired cognition, was heard to say no. CNA 5 left the room and returned at 4:28 a.m. with CNA 6. The CNA's were heard saying something garbled to the resident. The CNA's left the room with the resident lying on the floor. No staff checked on the resident after 4:28 a.m. until 6:20 a.m. when the day shift staff came in and assisted him up. The report indicated the CNA's had not attempted to assist him back into bed and left him there lying on the floor with his head resting on a shelf. Resident C's record was reviewed on 9/23/26 at 12:49 P.M. Diagnoses included severe dementia with mood disturbance, anxiety, and insomnia. A Level of Care assessment, dated 6/17/26, indicated		with falls or identified behavioral changes weekly for four weeks, then monthly for six months to ensure assessments and service plans accurately reflect resident needs. Identified concerns will be addressed promptly, with findings reviewed by regional clinical leadership. 5. Date of Compliance 4/19/2027	

	Resident C was at high risk for falls. The assessment indicated the resident had sundowning behaviors (worsening confusion in the evening and night), was disoriented to time and place, and had intermittent confusion. There were no specific behaviors or preferences to sleep on the floor documented in the assessment. A Service Plan, dated 6/17/26, indicated Resident C was to be monitored for changes in mood or behaviors. He could lose interest in completing activities of daily living (ADL) and refuse care or activities. Staff were to remind him when forgetful and if upset, redirect his attention to activities or conversations he was interested in. The service plan indicated he was at low risk for falls and staff were to monitor him while ambulating and provide assistance with transfers as needed. The Level of Care assessment had not indicated Resident C chose to sleep on the floor or had falls from bed. The Service Plan hadn't indicated sleeping on the floor was a behavior nor were interventions put in place if found lying or sleeping on the floor. Progress notes indicated: -9/3/26 at 1:15 p.m., Resident C was having trouble standing and			

	walking in the morning but later improved and was able to walk without assistance. -9/5/26 at 5:30 a.m., CNA 5 notified CNA 6, Resident C was lying on the floor next to his bed. He was observed lying on his right side, covered with blankets. He denied falling out of bed, pain, or distress. He was offered assistance back into bed but became agitated, raising his voice. He indicated he hadn't wanted to return to bed and preferred to remain on the floor. Multiple attempts were made to get him to get into bed but he refused. -9/5/26 at 10:30 a.m., the Regional Operations Specialist (ROS) received a call from the resident's Power of Attorney (POA) regarding an incident viewed through the resident's personal video camera in his apartment. The POA reported, on 9/5/26 at 4:18 a.m., the resident was observed on the floor by his bed. Staff had been observed going into his room but hadn't assisted him up off the floor. The POA was concerned staff hadn't reapproached him timely and let him lie on the floor for 2 hours. The ROS asked the POA if there were interventions on the resident's service plan indicating the resident had refusals and what staff interventions were.			

	The POA indicated she hadn't known but believed it was common sense to try and assist him up off the floor. -9/7/26 at 11:30 a.m., the medical Nurse Practitioner visited Resident C for fall follow up. He fell in his room on 9/5/26. There were no reports of injuries at the time. Orders were written to have physical therapy evaluate and treat him for weakness and falls. -9/8/26 at 2:00 p.m., the Regional Nurse Consultant (RNC) spoke with the residents POA and informed them of the resident having multiple falls and possible need for 1:1 care. On 9/24/26 at 11:57 A.M., Qualified Medication Aid (QMA) 7 was interviewed. She indicated Resident C had been having incidents of weakness and difficulty walking. She indicated he had history of falls without injuries. QMA 7 worked day shift on 9/5/26 and had assisted CNA 8 with getting Resident C off the floor. QMA 7 indicated the resident would, at times, put himself on the floor, but not to sleep. He wouldn't refuse assistance with getting back up. She had been concerned when told the resident had lain on the floor next to his bed for 2 hours and had refused assistance because			

	it wasn't his usual behavior. On 9/24/26 at 12:40 P.M., the Regional Nurse Consultant (RNC) was interviewed. The RNC indicated when residents were found on the floor, it was considered a fall and incident report, investigation, and changes to the service plan would be completed. If a resident were found on the floor and had a history of putting self on the floor, this would be reflected in the Level of Care Assessment and interventions placed on the Service Plan. This Citation relates to Intake 472031.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure care was provided based on individual needs and service plans for 3 of 4 residents reviewed (Resident B, Resident D, and Resident E). Findings include: 1. On 9/23/26 at 12:16 P.M., Resident B's Power of Attorney	R 0240	**Plan of Correction – R240** **Medication Administration** **1. Corrective Action for Affected Residents** Residents B has moved out. Resident D, and E will have their medication orders, medication administration records (MARs), and service plans reviewed by the clinical department head. Any identified concerns will be addressed with the prescribing provider, and service plans will be updated as indicated.	09/29/2026

	(POA) was interviewed. The POA indicated Resident B's antipsychotic medication hadn't been given, as ordered, since admission to the facility in June 2026. The psychiatric Nurse Practitioner (NP) discontinued the medication on 8/10/26 due to not taking the medication for the past 2 months. Resident B's record was reviewed on 9/23/26 at 1:07 P.M. Diagnoses included schizophrenia and dementia. A Service Plan, dated 6/2/26, indicated Resident B needed staff to assist with all aspects of medication management. A physician order, dated 6/2/26, was to give Seroquel (antipsychotic) 100 milligrams (mg) by mouth every day at bedtime. A Medication Administration Record (MAR), dated June 2026, indicated Seroquel was not available from the pharmacy and not administered 6/26/26 through 6/30/26. A MAR, dated July 2026, indicated Seroquel was not available from the pharmacy and not administered 7/1/26 through 7/31/26. A MAR, dated August 2026, indicated Seroquel was not available from the pharmacy		**2. Identification of Other Residents** The clinical department head or designee will complete an audit of current residents receiving medication assistance to identify any missed medications, unavailable medications, or medications requiring specially qualified staff. **3. Measures to Prevent Recurrence** • Medication administration staff will be reeducated on proper medication administration, MAR documentation, and timely notification of missed or unavailable medications. • The clinical department head or designee will verify that appropriately qualified staff are scheduled to administer insulin as ordered. • Staff will be educated on notifying the clinical department head immediately of medication availability concerns, missed doses, or staffing barriers. • The clinical department head will ensure timely follow-up with pharmacies and prescribing providers when medications are	

	and not administered 8/1/26 through 8/9/26. NP progress notes, dated 6/3/26, 6/15, 6/17, and 6/29/26, hadn't indicated Resident B was not receiving Seroquel as ordered. There were no NP progress notes for July 2026. A psychiatric NP note, dated 8/10/26, indicated Resident B was no longer taking Seroquel. Staff reported the resident had not been taking Seroquel since June 25, 2026 due to unsuccessful, repeated attempts to get the medication from the VA. The NP discontinued Seroquel and indicated the resident had no adverse effects from not being given the medication. A report, dated 9/22/26, alleged insulin was not being given to residents prescribed insulin, per physician orders. The report alleged, at other times, insulin was given by non-certified staff to residents prescribed insulin. 2. Resident D's record was reviewed on 9/23/26 at 3:00 P.M. Diagnoses included dementia and diabetes. A Service Plan, dated 7/22/26, indicated Resident D resided in a secured memory care community and needed her medications managed and administered by the nurse or		unavailable and document all attempts to receive medication in the EMR. **4. Monitoring for Continued Compliance** The clinical department head or designee will audit medication administration records weekly for four weeks, then monthly for six months to ensure medications are administered and documented appropriately. Any identified concerns will be corrected promptly, with additional staff education as needed. Audit findings will be reviewed with regional clinical leadership. **5. Date of Compliance** 4/19/2027	

	Qualified Medication Aid (QMA). A physician order, dated 12/6/24, was to give Lantus Solos insulin-inject 32 units subcutaneously 1 time daily at evening meal. A Medication Administration Record (MAR), dated August 2026, indicated Lantus Solos insulin injection was not documented as administered on 8/1/26, 8/3, 8/4, 8/6, 8/9, 8/11, 8/12, 8/13, 8/14, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, and 8/23/26. On 8/31/26 at 4:00 p.m., an entry on the August 2026 MAR indicated Lantus Solos insulin injection was not given due to no insulin certified staff available to administer the medication. 3. Resident E's record was reviewed on 9/23/26 at 2:22 P.M. Diagnoses included diabetes. A Service Plan, dated 6/16/26, indicated Resident E needed assistance with all aspects of medication management daily. A physician order, dated 1/4/25, was for insulin-Lantus Solos injection-inject 30 units subcutaneously 1 time daily for diabetes. A Medication Administration Record (MAR) dated June 2026, indicated Lantus insulin was not			

	documented as given on 6/14/26, as ordered. A MAR, dated July 2026, indicated Lantus Solos insulin injection was not documented as administered on 7/11/26 , 7/15, 7/16, 7/17, 7/22, 7/23, 7/25, 7/28, 7/29, 7/30, and 7/31/26. A MAR, dated August 2026, Lantus Solos insulin injection was not documented as administered on 8/1/26, 8/3, 8/4, 8/6, 8/9, 8/11, 8/12, 8/13, 8/14, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, and 8/31/26 when documentation on the MAR indicated no certified insulin staff member was available to administer. On 9/24/26 at 11:46 A.M., Employee 2 was interviewed. They indicated they were not insulin certified and could only administer oral medications. Employee 2 indicated Resident D and Resident E should receive insulin as ordered, daily by staff certified in insulin injections. They indicated if there was no one in the facility who was certified, the regional nurse consultant was to be notified. Employee 2 indicated blank boxes on the MAR indicated the insulin was not given. On 9/24/26 at 11:50 A.M., Employee 3 was interviewed.			

	They indicated they were not insulin certified and could only administer oral medications. Employee 3 indicated residents were to receive medications as ordered and signed off in the MAR by employee initials to indicated the medication had been given. Employee 3 indicated blank boxes on the MAR would indicate the insulin or other medications had not been given. On 9/24/26 at 11:57 A.M., Employee 4 was interviewed. They indicated they were not insulin certified and could only administer oral medications. They indicated if there was no one in the facility who was certified, the regional nurse consultant was to be notified. On 9/24/26 at 12:40 P.M., the Regional Nurse Consultant (RNC) was interviewed. The RNC indicated medications were to be given, according to physician orders, by staff trained and/or certified. She indicated there was no day she had been notified staff were no certified to give the insulins. A facility policy, titled Medication Administration, updated on 9/27/24, was provided on 9/23/26 at 2:20 P.M., by the Regional Operations Specialist. The policy indicated medications were to be			

	administered by a licensed nurse or delegated staff who were trained in medication administration. The facility would ensure residents were given the correct medications, at the correct times, in the right dosages, per physician orders. Staff were to record medication assistance provided to residents and maintain the medical records. A medication record (MAR) would be maintained for each resident receiving medication administration which would include name of the resident, name of medication/dosage/directions/route, date and time to be administered, and signature or initials of the employee administering the medication. This Citation relates to Intakes 471626 and 471834.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure a medication error, involving a discontinued	R 0247	R247 Medication Errors 1. Corrective Action for Affected Resident Resident B has discharged from the community to a higher level of care. No further direct resident care interventions are applicable. The identified medication error will be reviewed to ensure appropriate documentation and follow-up. 2. Identification of Other	09/29/2026

	antipsychotic medication, was identified, documented in the resident's record, and reported to the medical provider for 1 of 4 residents reviewed (Resident B). On 9/23/26 at 12:16 P.M., Resident B's Power of Attorney (POA) was interviewed. The POA indicated Resident B's antipsychotic medication hadn't been given, as ordered, since admission to the facility in June 2026. The psychiatric Nurse Practitioner (NP) discontinued the medication on 8/10/26 due to not taking the medication for the past 2 months. The POA indicated, for unknown reason, the antipsychotic medication was given to the resident after being discontinued. He was given the medication 8/13/26 until 9/8/26. Resident B's record was reviewed on 9/23/26 at 1:07 P.M. Diagnoses included schizophrenia and dementia. A Service Plan, dated 6/2/26, indicated Resident B needed staff to assist with all aspects of medication management. A physician order, dated 6/2/26, was to give Seroquel (antipsychotic) 100 milligrams (mg) by mouth every day at bedtime. A Medication Administration		Residents The Director of Nursing or designee will audit current resident medication orders and Medication Administration Records to identify discrepancies involving discontinued medications. Identified concerns will be addressed promptly. 3. Measures to Prevent Recurrence • Medication administration staff will be reeducated on medication error identification, reporting, documentation, and required notifications. • Licensed nursing staff will be reeducated on timely processing of new and discontinued medication orders. • Staff will be reeducated on resident monitoring and provider notification following medication errors. 4. Monitoring for Continued Compliance The DON or designee will audit discontinued medication orders and MARs weekly for four weeks, then monthly for six months to ensure orders are processed accurately and medication errors are identified,	

	Record (MAR), dated June 2026, indicated Seroquel was not available from the pharmacy and not administered 6/25/26 through 6/30/26. A MAR, dated July 2026, indicated Seroquel was not available from the pharmacy and not administered 7/1/26 through 7/31/26. A MAR, dated August 2026, indicated Seroquel was not available from the pharmacy and not administered 8/1/26 through 8/9/26. A progress note, dated 8/7/26 at 7:49 p.m., indicated Resident B's POA reported the NP needed to order and fax a copy of the order for Seroquel to the VA so the medication could be delivered to the facility. There was no written order for Seroquel, dated 8/7/26, in the resident's record. A psychiatric NP progress note, dated 8/10/26 at 11:30 a.m., indicated Resident B was seen for follow up due to no longer taking Seroquel. According to staff, the resident had been out of Seroquel medication since June, despite multiple attempts to refill the medication through the VA. Current psychiatric medications were reviewed. The resident received Risperdal 50 milligrams (mg) intramuscularly		reported, and documented. Any concerns will be corrected promptly, with findings reviewed by regional clinical leadership. 5. Date of Compliance 4/19/2027	

every 2 weeks at the VA. He was supposed to receive Seroquel 100 mg every day at bedtime per the VA. The resident had no adverse affects from not having the Seroquel so the medication would be discontinued.

The MAR, dated August 2026, indicated Seroquel was not given on 8/10, 8/11, or 8/12/26 because it had been discontinued. On 8/13 and 8/14/26, the MAR indicated Seroquel 100 mg had been given at bedtime. The medication was not given on 8/15/26 because the resident was out of the facility. Per the MAR, staff continued to administer Seroquel 100 mg by mouth at bedtime 8/18 through 8/30/26.

There was no order in the resident's record, to restart the Seroquel on 8/13/26. The August 2026 MAR, hadn't indicated the medication was discontinued on 8/10/26.

A MAR, dated September 2026, indicated the resident had been given Seroquel 100 mg by mouth at bedtime, on 9/1/26-9/7/26. On 9/8/26, Seroquel was discontinued and removed from the MAR.

Progress notes indicated:

-8/13/26 at 12:39 p.m., Resident

B's medications from the VA came in.

The progress note hadn't indicated which medications had been received.

-8/15/26 at 9:45 a.m., Resident B was unarousable at breakfast time and refused his meal. After breakfast, he remained asleep and slouched down in his recliner chair. Staff boosted him up in the chair to prevent him from falling and he hadn't woken up or reacted. The behavior was not normal for the resident.

-At 5:45 p.m., Resident B had a shower and went out to dinner with his family.

-8/26/26 at 12:30 p.m., the medical NP visited the resident. Resident B was subdued and less talkative than usual.

-9/3/26 at 8:33 p.m., Resident B refused his Seroquel. Resident would not wake up when attempts made to rouse him awake.

-9/8/26 at 11:00 a.m., clarification of resident medications was done with family. The resident's Seroquel had been discontinued on 8/10/26.

Resident B's record had not indicated a medication error had occurred when his Seroquel

was discontinued on 8/10/26, restarted on 8/13/26, and given daily until 9/8/26. There was no documentation to indicate either the medical NP or psychiatric NP were notified of the Seroquel being restarted after being discontinued. There was no documentation of family being notified of the medication being restarted after discontinued. There was no follow up documentation for episodes of inability to arouse from sleep on 8/15/26 or 9/3/26. There was no monitoring for side effects due to restarting Seroquel at his prior dose nor monitoring of side effects after the medication was abruptly discontinued.

On 9/25/26, information for Seroquel was retrieved from www.drugs.com. The website indicated Seroquel was an atypical antipsychotic medication used for schizophrenia. Elderly persons were to start at lower doses of Seroquel and gradually increased over time. Manufacturer directions was to start Seroquel at the lowest dose of 25 mg 2 times per day. The most common side effects were somnolence and lethargy. There was no data available to specifically address re-initiation of treatment but was recommended when restarting patients who had been off Seroquel for more than 1 week,

to use the initial dosing schedule.

On 9/25/26 at 10:15 A.M., the Regional Operations Specialist (ROS) was interviewed. She indicated medication errors were to be reported to the physician/NP, resident and their family. An incident report was to be completed and resident monitored. She indicated there had been no incident report completed for the medication error and neither she nor the Regional Nurse Consultant notified. Licensed Practical Nurse (LPN) 9 discontinued the Seroquel order on 9/8/26 and was unavailable for interview during the survey.

On 9/25/26, during a confidential interview, Employee 10 indicated Resident B's Seroquel had not been discontinued on the MAR, on 8/10/26 and continued to be given until the medication error was found on 9/8/26. Employee 10 contacted the medical NP when the error was found and the medical NP indicated she had not been notified or aware Seroquel had been given after discontinued on 8/10/26.

On 9/25/26 at 10:25 A.M., the medical NP was interviewed. The NP indicated she had been told the resident was off the Seroquel but then was back on it. She indicated the resident's

medical history had been spotty and was difficult to find information needed to provide his care. It was her understanding, the VA prescribed and supplied the resident's Seroquel and Risperdal. She was asked to write a prescription for Seroquel to send to the VA on 8/7/26 which she had done. The NP had not been notified when the medication error was found on 9/8/26.

On 9/25/26 at 10:55 A.M., the psychiatric NP was interviewed. She indicated she had not managed Resident B's orders for Seroquel and Risperdal due to the VA prescribing and supplying the medications. Prior to 8/10/26, she had not been told, the resident had not received the Seroquel due to the VA not supplying the medication. She had not been told the Seroquel had been restarted after she had discontinued the order.

A policy, dated 8/30/24, titled Medication Errors, was provided by the ROS on 9/24/26 at 3:00 P.M. The policy indicated medication errors were to be reported to the physician, resident and family. Any medication error required an incident report to be completed and followed up by the Director of Nursing, licensed nurse, or

	Executive Director. Medication errors should be reported to the physician by phone, followed up with a fax. The physician may want to withhold other medications, prescribe laboratory testing, or give other direction depending on the nature of the error. Staff were to monitor the resident and follow physician orders. This Citation relates to Intakes 471626 and 471834.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREVictoria Winchell	TITLERDON	(X6) DATE10/19/2026