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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: January 29 and 30, 2025 Facility number: 014512 Residential Census: 126 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 31, 2025	R 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. The plan of correction is submitted to meet requirements established by the state and federal law. Evergreen Village at Fort Wayne desires this plan of correction to be considered the facility's allegation of compliance. Compliance is effective 2/24/2025. Evergreen Village at Fort Wayne is respectfully asking for a desk review on this plan of correction.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure consistent food storage and sanitation practices in the kitchen. 126 of 126 residents resideting in the facility ate food prepared in the kitchen. Findings include: During an observation, on 1/29/25 at 09:00 AM, there were 5 consecutive days of missing temperature and chemical measurements for the dishwasher. During an observation, on 1/29/25 at 9:10 AM, the dry pantry had a bottle of cinnamon on the	R 0273	**R273** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** On 1-29-25 all opened items found to not have open dates in freezer, dry storage and walk-in cooler were immediately thrown out. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	02/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Nelson	Executive Director	02/18/2025

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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	floor. There were no open dates on an open bag of pasta noodles, open bag of tortillas, or an open bag of cereal. An unopened bag of cereal was found on the floor. During an observation on 1/29/25 at 9:16 AM, the walk-in freezer had missing open or use-by dates on an unsealed box of beef patties and a bag of mixed vegetables. During an observation, on 1/29/25 at 9:20 AM, in the walk-in refrigerator had 2 of 6 cottage cheese containers expired on 1/13/25. An open bag of baby carrots expired on 12/13/24. The refrigerator door gasket had small, black, round spots on all sides of the doorway. In a cooler, near the steam stable, cottage cheese expired on 1/13/25. During an observation, on 1/29/25 at 9:15 AM, 2 of 3 large bins containing flour and oats did not have an open date or use-by date labels. During an observation, on 1/29/25 at 10:50 AM, signs had been posted on 2 refrigerator doors, walk-in freezer door, and dry pantry door indicated "Stop! Is it labeled? Is it dated? Is it sealed?..." An additional sign had been posted on the cooler near the steam table indicating all items in this cooler need to be checked daily for dates and discarded when they expire. In an interview, on 1/29/25 at 11:30 AM, resident 90 indicated hygiene concerns from staff during meal service. The resident indicated he has watched staff tie shoes or wipe their own nose during meal service and not perform hand hygiene. In an interview, on 1/29/25 at 11:40 AM, resident 60 indicated multiple staff members have not worn		**taken?** No residents were affected by the deficient practice. On 1-29-25 a full audit of all areas in the kitchen was completed by dietary manger to ensure there were no other open and undated food items. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** Dietary staff educated on labeling and dating of open items. Dietary manager or designee will complete weekly audits of freezer, dry storage, walk in cooler and salad station to ensure accuracy of labeling and dating of opened items. Dietary manager or designee will complete a monthly audit using the Residential Care Kitchen/Food Service Observation form. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place and** Dietary manager or designee will complete weekly audits of freezer, dry storage, walk in cooler and salad station to ensure accuracy of labeling and dating of opened items for 100% accuracy for 6 months. Dietary manager or designee will complete a monthly audit for 6 months using the	

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	a hairnet during meal service. In an interview on 1/30/25 at 1:03 PM, with the Dietary Manager, indicated signs posted on food storage doors were current expectations for labeling, dating, and sealing food items. A current dietary hair management policy, provided on 1/29/25 at 11:20 AM by the Dietary Manager, indicated cap or hairnets must be worn in the kitchen. A current food storge policy, provided on 1/30/25 at 1:22 PM by the Dietary Manager, indicated refrigerated foods shall indicate the date by which the food shall be consumed and may not exceed a manufacturer's use-by date. The policy indicated food items would be discarded if the container was not labeled with use-by date or exceeds use-by date.		Residential Care Kitchen/Food Service Observation form. Any issues or concerns will be forwarded to the Executive Director and QAPI team for follow-up and resolution. **By what date the systemic changes will be completed.** 2/24/2025	
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance Based on interview and record review, the facility failed to ensure complete documentation in a clinical record for 1 of 2 resident records reviewed (Resident 50). Findings include: Resident 50's record was reviewed on 1/30/25 at 9:50 AM. Diagnoses included heart failure and diabetes. A progress note, dated 11/8/24 at 3:00 PM, indicated Resident 50 had been admitted to hospice services.	R 0357	**R357** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #50 no longer resides in the community. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to	02/24/2025

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	A progress note, dated 11/14/24 at 7:07 PM, indicated the hospice nurse had been notified of Resident 50 being lethargic and having a low oxygen level. A progress note, dated 11/16/24 at 3:45 PM, indicated the hospice nurse was notified of Resident 50's condition decline. A progress note, dated 11/16/24 at 6:30 PM, indicated Resident 50 had been administered morphine. No progress notes were entered for Resident 50 on 11/17/24, 11/18/24, or 11/19/24. A progress note, dated 11/20/24 at 1:20 PM, indicated Resident 50 had new medication orders. A progress note, dated 11/20/24 at 4:04 PM, indicated Resident 50 had passed away at 3:27 PM. The hospice nurse had received a physician order to release the resident's remains to the funeral home. A Provisional Notification of Death-Burial Transit Permit indicated Resident 50 had passed away on 11/20/24 at 3:27 PM. A Release of Body form, dated 11/20/24, indicated Resident 50 had passed away at 3:27 PM. The Personal Items Released section was blank. In an interview, on 1/30/25 at 11:35 AM, the Administrator indicated they were not aware of the documentation process related to the release of a resident's personal belongings and medications. The Administrator indicated the resident's hospice provider should have documentation of the release of Resident 50's		be affected by the deficient practice. Education provided to Licensed nurses regarding documentation on vitals preceding death and disposition of resident, medications and belongings upon discharge. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** A checklist was created by DON to verify that documentation of all information is in a resident's medical record. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place and** The DON or designee will monitor resident discharges as they occur for 6 months for 100% compliance . Any issues or concerns will be forwarded to the Executive Director and QAPI team for follow-up and resolution. **By what date the systemic changes will be completed.** 2/24/2025	

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	personal belongings and medications. On 1/30/25 at 3:43 PM, the Administrator provided Resident 50's hospice notes dated 11/8/24 through 11/19/24. A hospice visit note, dated 11/17/24 at 4:17 PM, indicated the resident had been fully assessed. The facility had contacted the hospice nurse due to Resident 50 being semi-comatose. The resident had a temperature of 99.3 and had labored breathing. A hospice visit note, dated 11/18/24 at 4:14 AM, indicated the resident had been fully assessed. The facility had contacted the hospice nurse due to Resident 50's pain medication being ineffective. The resident was moaning and had labored breathing. An additional dose of morphine was given. A hospice visit note, dated 11/18/24 at 1:53 PM, indicated the resident had been fully assessed. Resident 50 had a temperature of 100.4 degrees Fahrenheit and had an irregular breathing pattern. A hospice visit note, dated 11/19/24 at 11:54 AM, indicated the resident had been fully assessed. Resident 50 had a temperature of 102 degrees Fahrenheit. The note indicated the resident had an irregular breathing pattern. The hospice notes did not include an assessment of Resident 50's condition on 11/20/24. The hospice notes did not include the disposition of the resident's personal belongings or medications. A current facility policy, titled "Death of a Resident," dated 4/2024, provided by the Administrator on 1/30/25 at 2:05 PM indicated the release of resident belongings would be			

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	documented. The policy indicated the details of the release of personal items would be documented in a Release of Body Form and in the residents' progress notes.			