STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Nursing and Rehabilitation Center	2827 Northgate Blvd Fort Wayne, IN 46835

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure privacy of personal health information for 3 of 25 residents reviewed (Resident 7, Resident 56, and Resident 78). Findings include:In an observation, on 9/26/2025 at 8:43 AM, the 100 hall nurses cart was unattended in the hallway with residents in the area. A worksheet containing vital signs and other resident information for Resident 56 and Resident 78 was lying face up on top of the cart. A stickered medication card with Resident 7's name on a medication label was lying on top of the cart in full view. The label indicated the medication ordered was Vitamin D 50 mcg tablets, take 2 tablets once daily.During an interview, on 09/26/2025 at 8:48 AM, Registered Nurse 2 indicated he was instructed to go to the dining room immediately and had left his cart unattended because he was in a hurry.In an interview on 09/26/2025 at 8:48 AM, the Director of Nursing indicated worksheets with resident information should not be left on top of the cart in full view. She indicated medication cards containing a resident's name and medication orders should not be visible on top of the cart.1) Resident 56's record was reviewed on 09/26/2025 3:00 PM. Diagnoses included chronic obstructive pulmonary disease and type 2 diabetes mellitus. A review of Resident 56's current quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 78 had a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). 2) Resident 78's record was reviewed on 09/26/2025 3:00 PM. Diagnoses included chronic obstructive pulmonary disease and type 2 diabetes mellitus. A review of Resident 78's current quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 78 had a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). 3) Resident 7's record was reviewed on 09/26/2025 2:47 PM. Diagnoses included type 2 diabetes mellitus with diabetic neuropathy and idiopathic aseptic necrosis of the right femur. A current quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated Resident 7 had a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). A current physician's order, dated 8/21/25, indicated Vitamin D 50 mcg, two tablets, to equal 100 mcg should be administered to Resident 7 once daily. A current policy, tilted Safeguarding Protected Health Information, provided by the Administrator on 09/29/2025 9:55 AM, indicated paper records should be stored in a way that avoids access by unauthorized persons. 3.1-39(o)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Nursing and Rehabilitation Center	2827 Northgate Blvd Fort Wayne, IN 46835

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure timely resident assessment and care for 1 of 23 residents reviewed (Resident 117).Findings include:Resident 117's record was reviewed on 09/25/2025 10:58 AM. Diagnoses included Type 2 diabetes mellitus, depression, hypertension, chronic pain syndrome, and polysubstance disorder.Resident 117's current admission Minimum Data Set assessment dated [DATE] had not been completed at the time of facility exit. Nurse Practitioner 11's progress notes, dated 9/22/25 2:15 PM, indicated Resident 117 had been admitted to the hospital from [DATE] to 9/21/25 for a 2-week history of watery stools, increased weakness, confusion, nausea, syncope, and poor oral intake. The progress note indicated Resident 117 was alert and a poor historian with inconsistent responses.Resident 117's census records indicated he was readmitted to the facility on [DATE] 12:37 PM.Observations including the admission assessment, Braden scale skin risk assessment, fall risk assessment and pain assessment dated [DATE] were blank and did not include any assessment information.Resident 117's current care plan titled requires assistance and/or monitoring indicated the resident had a problem of needing assistance with activity of daily living care, nutrition, hydration and elimination, with a goal date of 10/5/2025. Interventions included recording breakfast, lunch and dinner intakes.Resident 117's current care plan titled requires implementation of services indicated the resident had problems including type 2 diabetes with neuropathy, chronic kidney disease and history of substance abuse, with a goal date of 10/5/2025. Interventions included providing medications and treatments per physician's orders.A review of Medication Administration Records (MAR), dated September 2025, indicated Resident 117 had an order dated 9/21/2025 to have a blood glucose check twice daily. A blood glucose check scheduled for the evening of 9/21/2025 was recorded as not completed documented as due to waiting for pharmacy. No additional notes were available for review. Vital signs spaces for first shift and second shift on 9/21/25 were blank. The space for Resident 117's weight on 9/22/2025 indicated a weight was not done and would be completed by restorative staff.A review of vital signs records indicated a blood glucose level of 168 was obtained by Licensed Practical Nurse (LPN) 7 on 9/23/2025 at 7:23 AM. No blood glucose readings prior to that encounter were available for review. A weight reading of 240 lbs. was obtained on 9/25/2025 at 2:05 PM by the dietician.On 9/22/2025 at 2:39 AM, a blood pressure reading of 145/87, a pulse of 77 beats per minute, a respiratory rate of 20 per minute, and a temperature of 97.8 were obtained by LPN 9. No vital signs prior to that encounter were available for review.A review of progress notes dated 09/22/2025 01:00 AM indicated LPN 9 performed nursing assessments for Resident 117. No notes or assessment forms were recorded for Resident 117 prior to this encounter.A review of meal intake records did not include records of food or fluid offerings or intakes for breakfast or lunch on 9/22/2025. No records of food or fluid offerings or intakes for breakfast, lunch, or dinner on 9/23/2025.During an interview, on 09/25/2025 1:13 PM, the Director of Nursing (DON) indicated upon arrival to the facility, staff should bring a newly admitted resident to their room and perform assessments as soon as possible, including a full head-to-toe assessment, vital signs, and a skin assessment. She indicated the admitting nurse should ensure medication orders, treatment orders, ancillary and appointment orders were carried out and any specialty equipment was available for the resident. The DON indicated she observed the admission Observation, the Braden Scale assessment, The Fall Risk Assessment, and Pain assessment observation forms in Resident 117's electronic medical record had not been filled out and did not contain required nursing assessment information. She indicated the forms should have been filled out as soon as possible after admission and indicated she would consult her facility policy for the exact time frame. She indicated the forms should have been filled out by the time of review.In an interview, on 09/25/2025 4:19 PM, the Administrator indicated she had spoken to the first and second shift nurses on duty 9/21/25 and each had indicated they did not obtain vital signs or perform assessments on Resident 117 during (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Nursing and Rehabilitation Center	2827 Northgate Blvd Fort Wayne, IN 46835

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their shifts on 9/21/25. A current policy, dated 7/2024, provided by the Administrator on 9/25/25 at 2:37 PM indicated the admitting nurse should introduce themselves to the resident and family at the time of the admission and orient the resident to their room and surroundings and inform them of the day's events. The policy indicated the admitting nurse should interview the resident and/or family to complete the admission assessment. The initial nursing assessment should be completed within 24 hours of admission including height and weight. The policy indicated all residents should be assessed every shift for the first 72 hours following admission. The policy indicated a thorough head-to-toe assessment must be done at the time of admission in addition to a Braden Scale assessment and fall risk assessment.3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Nursing and Rehabilitation Center	2827 Northgate Blvd Fort Wayne, IN 46835

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review the facility failed to ensure pain management was provided and documented for 1 of 3 residents reviewed. (Resident 2)Findings include:A record review for Resident 2 began on 9/23/2025 at 2:13 PM. Diagnoses included chronic pain syndrome, displaced intertrochanteric fracture of right femur, sleep apnea, delirium due to known physiological condition, and recurrent major depressive disorder.A review of Resident 2's current quarterly MDS, 8/7/25, indicated their BIMS (Basic Interview for Mental Status) score was 8 (cognitively impaired).A review of Resident 2's current Care plan, titled Resident will be free from adverse effects of Pain, indicated the resident had a problem of pain, with a goal date of 12/03/2025. Interventions included observation of adverse side effects of pain medication including, but not limited to over sedation, constipation, skin rash, nausea/vomiting, loss of appetite, change in mental status, stomach upset. Document abnormal findings and notify MD. Notify MD if pain is unrelieved and/or worsening. Administer meds as ordered. Observe for non-verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture.A review of physician orders, dated 7/25/25, indicated Asper creme (lidocaine) patch was to be administered once a day.A review of the medication administration record dated 8/1/25-8/31/25 indicated missing documentation of administration of Asper creme on 8/30/25 for 7:00 AM to 11:00 AM.A review of the medication administration record dated 9/1/25-9/29/25 indicated documentation was missing for the administration of Asper creme on 9/8/25 and 9/11/25 for 7:00 AM to 11:00 AM.A review of physician orders, dated 7/7/25, indicated Tylenol (acetaminophen) 650 mg, was to be given orally, every 8 hours.A review of the medication administration record, dated 8/1/25-8/31/25, indicated missing documentation of administration of Tylenol on 8/11/25 at 8:00 AM.A review of the medication administration record dated 9/1/25-9/29/25 indicated documentation was missing for the administration of Tylenol on 9/4/25 at 12:00 AM, 9/5/25 at 12:00 AM, 9/8/25 at 12:00 AM, 9/14/25 at 12:00 AM, 9/28/25 at 12:00 AM. A review of nursing progress notes, dated 7/13/25 to 9/29/25, indicated no documentation regarding missing Asper creme and Tylenol doses was completed. None of the nurses notes indicated a reason the medications were not given.The noted did not indicate the physician had been notified of the missed doses.In an interview, on 09/29/2025 at 10:41 AM, LPN 8 indicated documentation was needed for each scheduled administration of a medication. A reason why medication was not given should be entered into the MAR, examples included when a resident was out of the building, or a medication was refused, or not in stock. In an interview, on 09/29/2025 at 11:19 AM, the Director of Nursing indicated all routine medications should be documented on the MAR. The administration team reviewed all medication reports during the daily morning meeting. When there was something missing, the administration team would investigate and have the staff member correct the documentation for accuracy. In an interview, on 9/29/2025 at 11:47 AM, Resident 2 indicated her back gets painful. Resident 2 indicated she had missed doses of her pain medications. A current policy provided by the Administrator indicated After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: document necessary medication administration/treatment information (eg when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms.A current policy dated 7/2024, provided by the regional nurse, indicated residents are assessed for pain upon admission, weekly and during medication administration as outlined. The following will be used when assessing pain,3.1-37(a)