STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Byron Health Center	1661 Beacon Street Fort Wayne, IN 46805

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44036 Based on interview and record review the facility failed to ensure fall prevention interventions were followed for 1 of 4 resident reviewed (Resident B). Findings include: A facility reported incident file was provided by the Executive Director on 2/21/25 at 10:15 AM. The file included the following: The file, dated 2/4/25, indicated around 6:40 PM, Certified Nurse Aide (CNA) 5 assisted Resident B in the shower. Resident B was in the shower chair, started to foam at the mouth and turned blue. CNA 5 ran out of the room, left the resident alone in the shower chair, and got help. Upon return, CNA 5 and Qualified Medication Aide (QMA) 4 found Resident B on the floor of the shower. CNA 5's statement, undated, indicated while she assisted Resident B with a shower, Resident B foamed at the mouth. CNA 5 indicated she ran to get the nurse and upon return found Resident B on the floor of the shower. CNA 5's statement also indicated she did not witness the fall as she had ran to get the nurse and then came back. CNA 5 indicated she had left Resident B alone in the shower chair. QMA 4's statement, undated, indicated she was alerted by CNA 5, Resident B had turned blue and foamed at the mouth. QMA 4 indicated when she entered the room, Resident B was observed on the floor of the shower. In at interview, on 2/21/25 at 11:35 AM, the Director of Nursing (DON), indicated CNA 5 assisted Resident B with a shower in the shower chair. The DON indicated Resident B started to foam at the mouth and turned blue. The DON indicated CNA 5 left Resident B alone in the shower chair and ran to get assistance. The DON indicated when CNA 5 and QMA 4 returned to the room, Resident B was on the floor. The DON indicated Resident B had an unwitnessed fall while CNA 5 was out of the room. In an interview, on 2/21/25 at 11:25 AM, QMA 7 indicated when a resident was in the shower chair, the resident should never be left alone. QMA 7 indicated when additional assistance was needed, the call light should be pulled or staff yell out for help. QMA 7 indicated she would never leave the resident alone. (continued on next page)

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
	155364	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Byron Health Center	1661 Beacon Street Fort Wayne, IN 46805

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 2/21/25 at 11:08 AM, CNA 6, indicated a resident was never left in the shower chair alone. CNA 6 indicated when a resident became unresponsive or had a change in condition while in the shower, she pulled the call light or yelled for help. Resident B's record was reviewed on 2/21/25 at 10:54 AM. Diagnosis included: history of a traumatic brain injury, muscle weakness, and quadriplegia. A quarterly fall assessment, dated 11/20/24, indicated Resident B was at high risk for falls. A current care plan indicated Resident B had a history falls due to a traumatic brain injury. The care plan indicated Resident B needed assistance with transfers and showers. A policy, dated 10/2005, titled Falls - Clinical Protocol, was provided by the DON on 2/21/25 at 11:45 AM. The policy did not indicate fall prevention interventions for high fall risk residents. This citation relates to Complaint IN00452850. 3.1-45(a)