| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155364 | A. Building<br>B. Wing | 05/19/2025 |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>45243<br><br>Based on observation, record review, and interview the facility failed to ensure dignity was maintained for 1 of 1 resident reviewed. (Resident 10)<br><br>Findings include:<br><br>During an observation, on 5/15/25 at 7:26AM, Licensed Practical Nurse (LPN) 6 administered medications to Resident 10. The medications were administered in a common area while Resident 10 was sitting eating breakfast at dining table.<br><br>The medications administered included Trulicity, a subcutaneous injection of a hypoglycemic agent. The Trulicity injection was administered in Resident 10's right upper quadrant of his abdomen after Resident 10 pulled up his shirt revealing his abdomen.<br><br>In an interview, on 5/15/25 at 9:56AM, LPN 6 indicated she normally would stop giving medications and assist in serving breakfast rather than administering medications during breakfast.<br><br>In an interview, on 5/15/25 at 10:10AM, Registered Nurse (RN) 5 indicated nurses were not permitted to give medications in the common area during breakfast due to dignity issues as well as residents were to enjoy their meal without interruptions.<br><br>Resident 10's record review began on 5/15/25 at 2:06PM. The record indicated diagnoses included type 2 diabetes, chronic gingivitis, and unspecified dementia. Resident 10's care plan did not specify a preference to take medications in the common areas.<br><br>A current policy, titled Quality of Life-Dignity undated, was provided by the administrator on 5/15/25 at 10:23AM. The policy indicated, 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .9.Staff shall maintain an environment in which confidential clinical information was protected, for example: b. signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or the resident's family member. Discreet posting of important of information 10. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .<br><br>(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 |
|---|---|---|

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current policy, titled Administered Oral Medications undated , was provided by the Administrator on 5/15/25 at 10:23AM. The policy indicated, 26. If the resident desires, return the door and curtains to the open position .<br><br>3.1-3(a) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756<br><br>Based on observation, interview and record review the facility failed to ensure privacy of electronic and paper medical information for 1 of 20 residents reviewed. (Resident 80)<br><br>Findings include:<br><br>During an observation, on 5/14/25 at 10:30 AM, a computer screen on top of a medicine cart was open with Resident 80's name, picture, medication list and other personal health information visible on the screen. A paper worksheet was lying on top of the medicine cart displaying vital signs and other health information for residents on the unit. The medicine cart was observed in a hallway leading to the common areas of the unit where staff and residents were observed passing by.<br><br>During an observation, on 5/14/25 at 12:31 PM, Registered Nurse (RN) 5 was observed seated next to Resident 80 in the dining room assisting her with lunch. RN 5 rose from her chair, walked to the medicine cart, activated the lock and returned to her seat. The computer on top of the medicine cart was open to Resident 80's medication list and picture. A worksheet with visible vital signs and other resident information was observed sitting on top of the cart. Residents and staff were walking around the area preparing for the lunch meal and were in close enough proximity to view the computer screen and paper.<br><br>Resident 80's record was reviewed on 5/14/25 at 1:14 PM. Diagnoses included cerebral palsy, abnormal weight loss, dysphagia, and altered mental status.<br><br>A review of Resident 80's current significant change Minimum Data Set Assessment (MDS) dated [DATE] indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired).<br><br>During an interview, on 5/14/25 at 12:40 PM, RN 5 indicated she had prepared and administered Resident 80's medications, but had forgotten to lock the screen when she stepped away from the cart. She indicated the computer screen should have been locked and the worksheet should have been turned over to keep resident information private.<br><br>During an interview, on 5/16/25 at 12:26 PM, the Director of Nursing (DON) indicated computer screens should be locked when staff were not present and attending to them. The DON indicated any paper records should not have visible resident information in unsecured areas, such as on top of medication carts.<br><br>A current policy titled Protected Health Information, Management and Protection of, dated 4/07 provided by the Administrator on 5/16/25 at 1:12 PM indicated all personnel with access to resident information should ensure the information is managed and protected to prevent unauthorized disclosure.<br><br>A current policy titled Confidentiality of Information, dated 7/10/19, indicated all resident records should be safeguarded to protect the confidentiality of the information. The policy indicated access to medical records should be limited to staff and consultants providing care to the resident.<br><br>3-1(p)(5) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>45243<br><br>Based on record review and interview the facility failed to ensure a bed hold policy was given prior to discharge to 2 of 3 residents reviewed. (Resident 35 and Resident 47)<br><br>Findings include:<br><br>1) Resident 35's record review began on 5/13/25 at 10:33AM. Resident 35's diagnoses included kidney failure, respiratory failure, and pneumonitis due to inhalation of food and vomit.<br><br>On 10/8/24 Resident 35 was sent to the hospital. There was no documentation to indicate a bed hold had been explained to her or the family in the medical record. The facility was unable to show proof a bed hold was given prior to discharge.<br><br>2) Resident 47's record review began on 05/14/25 at 1:34 PM. Resident 47's diagnoses included respiratory failure, dysphagia, and altered mental status.<br><br>Resident 47 was sent to the hospital on 3/8/25 there was no documentation to indicate a bed hold had been explained to him or his family in the medical record. The facility was unable to provide proof a bed hold was given prior to discharge.<br><br>In an interview, on 05/16/25 at 12:27 PM, the Director of Nursing (DON) indicated a bed hold policy should have been documented in the progress notes. The DON indicated the resident, a family member, or power of attorney should always be informed of a bed hold policy at discharge prior to leaving the building.<br><br>A current policy titled, Holding Bed Space was provided by the Administrator on 5/16/25 at 1:12PM. The policy indicated, Our facility shall inform residents upon admission and prior to transfer for hospitalization s or therapeutic leave of our bed-hold policy .<br><br>No state rule applies. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>45243<br><br>Based on observation, interview and record review the facility failed to ensure assessments were accurately recorded for 2 of 2 residents reviewed. (Resident 1, Resident 35)<br><br>Findings include:<br><br>During an observation on 05/16/2025 at 1:38 PM the following was observed: the Director of Nursing approached Resident 1 to check pupils. Upon shining a flashlight in the left eye, the pupil appeared dilated, round and nonreactive to light; the right pupil appeared round, non-dilated, and reacted to light.<br><br>Resident 1's record was reviewed on 05/14/2025 at 12:53 PM. Diagnoses included 6th abducent nerve palsy (affects the ability to turn the eye outward), 3rd oculomotor nerve palsy (affects the ability for eye to look straight ahead, also effects the pupils ability to constrict to light leaving the pupil dilated), and blepharoconjunctivitis (inflammation of the eyelid and conjunctiva (mucus membrane of eye)).<br><br>A review of Resident 1's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 5 (severe cognitive impairment).<br><br>A review of Resident 1's current care plan titled Impaired Vision related to dry eye syndrome, blepharitis (inflamed, itchy eyelids), and ptosis (eyelids droop over eye) indicated the resident had a problem with inflamed, droopy eyelids, with a goal date of 07/23/2025. Interventions included washing eye lids with baby shampoo as ordered, referring to optometry as ordered, and head CT scan as ordered. There was no care plan for unequally sized pupils.<br><br>A review of progress notes dated 04/30/2025 at 11:43 AM indicated when Resident 1 was seen by the eye doctor, they recommended for her to be sent to the ER for ptosis. The eye doctor believed it could be life threatening. Resident 1 refused to have an MRI performed, but agreed to a CT of the head. Resident 1 had known irregular pupils, had no mental status changes, no headache, no recent head trauma, and no complaints of eye pain.<br><br>Skilled charting dated 2024 indicated Resident 1's pupils were equal, round, and reactive to light on 07/08, 07/16, 07/22, 07/29, 08/06, 08/12, 08/19, 08/27, 09/02, 09/09, 09/17, 09/30, 10/05, 10/14, 10/21, 10/29, 11/04, 11/05, 11/19, 11/25, 12/02, 12/19, and 12/25.<br><br>Skilled charting dated 2025 indicated Resident 1's pupils were equal, round, and reactive to light on 01/01, 01/09, 01/22, 02/05, 02/12, 02/20, 03/13, 04/02, 04/03, and 04/24.<br><br>A review of Resident 1's CT of the Head without contrast, dated 05/08/2025, indicated no acute findings.<br><br>In an interview, on 05/14/25 at 10:34 AM, the Administrator indicated Resident 1's pupils had been unequal in size since 2022.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview, on 05/14/25 at 12:53 PM, the DON indicated the PERRLA (Pupils Equal, Round, and Reactive to Light and Accommodation) documentation needed to be better, and staff would be educated on performing neurological assessments and documentation.<br><br>In an interview, on 05/16/25 at 09:40 AM, LPN 7 indicated pupils are to be checked when a fall happens and with mental status changes. Resident 1 had not had any mental status changes recently and the nurse was not aware of the resident having unequal pupils.<br><br>In an interview, on 05/16/25 at 10:00 AM, RN 5 indicated skilled assessments are typically done weekly. If an assessment was missed, then she would make sure to get that done and charted.<br><br>Resident 35's record was reviewed on 05/13/25 at 10:33 AM. Diagnoses included acute respiratory failure with hypoxia, pneumonitis (swelling and irritation of lungs) due to inhalation of food and vomit, and dysphagia (difficulty eating).<br><br>A review of Resident 35's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 3 (severe cognitive impairment).<br><br>A review of physician's orders, dated 11/13/24, indicated to focus documentation for breath sounds, fever, oxygen saturation below 92% on room air, and increased respiratory rate greater than 24 breaths per minute every shift for 7 days.<br><br>A review of physician's orders, dated 11/13/24, 11/25/24, and 12/20/24, indicated Resident 35 received chest X-rays for pneumonia and pleural effusion (fluid accumulation between lungs and chest wall).<br><br>A physician's order, dated 12/11/24, indicated to completeanother follow up chest X-ray for pneumonia with effusion drainage related to recent chest tube removal.<br><br>Change in condition supportive documentation, dated 11/15/24, indicated no breath sounds were assessed on second shift. On 11/16/24 no breath sounds were assessed for first or second shift.<br><br>On 11/17/24 no breath sounds were assessed for third shift.<br><br>In an interview, dated 05/14/25 at 10:53 AM, the DON indicated Resident 35 should have been assessed every shift as ordered.<br><br>A current policy, dated 02/2014, provided by the DON indicated neurological assessments should include drooping eyelids, facial paralysis, asymmetry, and pupil size.<br><br>A current policy dated 02/2014 provided by the DON indicated lung sounds, respirations, cough, consistency and color of sputum, oxygen use and oxygen saturations, and shortness of breath should be assessed during comprehensive assessments.<br><br>3.1-37<br><br>46818 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756<br><br>Based on observation, interview and record review, the facility failed to ensure oxygen tubing was appropriately applied and stored when not in use for 1 of 2 residents reviewed. (Resident 28)<br><br>Findings include:<br><br>During an observation on 5/13/25 at 12:04 PM oxygen tubing was lying across Resident 28's bed unbagged. The bedside oxygen concentrator was turned on, releasing oxygen while Resident 28 was in the dining room.<br><br>During an interview on 5/13/25 at 12:05 PM, Licensed Practical Nurse (LPN) 2 indicated bedside oxygen should be turned off when not in use and oxygen tubing should be bagged when not in use. LPN 2 indicated she was unable to find a bag in Resident 28's room to place her oxygen tubing in.<br><br>During an observation on 05/15/25 10:19 AM, Resident 28 was observed lying on her right side in bed with her chin tucked to her chest, breathing in a labored manner. She was not wearing the oxygen. Resident 28's oxygen tubing was about 2.5 feet away from the resident lying neatly coiled, unbagged on a bedside table. The tubing was attached to an oxygen concentrator that was turned on and releasing oxygen. Resident 28's wheelchair was about 8 feet away from her bed.<br><br>Resident 28's record was reviewed on 5/15/25 at 10:28 AM. Diagnoses included chronic respiratory failure with hypoxia, hypoxemia, shortness of breath, and need for assistance with personal care.<br><br>A review of Resident 28's current quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired). The MDS indicated the resident utilized oxygen therapy.<br><br>A review of Resident 28's current care plan regarding Impaired gas exchange indicated the resident had a problem of shortness of breath, with a goal date of 7/5/25. Interventions included monitoring for signs and symptoms of acute respiratory insufficiency including labored breathing and administering oxygen as directed.<br><br>A review of physician orders dated 2/17/25 at 4:00 PM indicated oxygen should be administered up to 5 liters per minute for hypoxia or shortness of breath.<br><br>A review of progress notes did not indicate any refusal of care or oxygen dated 5/15/25.<br><br>During an interview on 5/15/25 at 10:23 AM, LPN 3 indicated Resident 28 was poorly positioned due to the head of the bed being raised and the resident sliding down causing her chin to tuck toward her chest resulting in labored breathing. She indicated Resident 28 would not have been able to place her oxygen tubing on the table as it was out of her reach and physical ability. She indicated Resident 28 was not able to self-transfer or walk from where her wheelchair was positioned across the room. She indicated Resident 28 should have been positioned better and should have had her nasal cannula placed in her nostrils.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current policy dated 10/2010, provided by the Administrator on 5/15/25 at 11:35 AM indicated staff should turn on the oxygen at the time of application and place the oxygen device on the resident.<br><br>A current policy titled Oxygen Storage, dated 8/22/14 did not address storage of oxygen supplies when not in use.<br><br>3.1-47(a)(6) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756<br><br>Based on observation, interview and record review the facility failed to ensure kitchen sanitation was maintained, opened food items were labeled and dated, and baking trays were thoroughly air dried. 95 of 96 residents residing in the building were served food prepared in the kitchen.<br><br>Findings include:<br><br>During an observation on [DATE] at 9:07 AM, A container of ice cream was observed in the walk-in freezer. The dietary manager (DM) opened the container and dip marks where ice cream had been removed were observed. No open date was observed on the container.<br><br>A large, covered cart was observed in the back of the walk-in cooler with a discard date of [DATE]. The DM lifted the cart cover revealing individual pieces of cake on plates and bowls of fruit. The fruit and cake were not individually covered and appeared dry.<br><br>A large bin labeled flour was observed with a scoop lying in the flour supply. A large bin labeled sugar was observed with a scoop lying in the sugar supply.<br><br>Four chef salads were observed on plates covered with plastic wrap inside the reach-in cooler. No date was observed on any of the salads.<br><br>An open box of popsicles was observed in the reach in freezer with an expiration date of [DATE].<br><br>A box was observed inside a reach in freezer containing frozen hamburger patties inside a plastic bag. The plastic bag was open leaving the meat open to air. A plastic bag containing breaded chicken strips was observed on a shelf in the freezer. The plastic bag was open with the meat open to air. A plastic bag containing French fries was open with the French fries open to air. No open dates were observed on the hamburger patties, chicken strips or French fries.<br><br>A shelf next to the fryer was observed with a large amount of yellow oily liquid and brown specks of debris. The reach in freezer across from the fryer had multicolored streaks and splatters on the front of the doors.<br><br>3 of 4 baking pans had clear liquid dripping from them when separated in the ready to use baking pan storage stack.<br><br>In an interview on [DATE] at 9:08 AM, the Dietary Manager (DM) indicated the container of ice cream should have been dated when opened.<br><br>The DM indicated the cart containing the expired fruit and cake should have been disposed of on [DATE].<br><br>The DM indicated scoops for flour and sugar should be stored outside the supply.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The DM indicated salads in the reach-in cooler should have been dated.<br><br>The DM indicated the expired box of popsicles should have been discarded upon expiration.<br><br>The DM indicated packages frozen hamburgers, chicken strips and French Fries should be closed after use to prevent air exposure and dated when opened.<br><br>The DM indicated the fryer area, including the freezer doors, should have been cleaned after its last use, the previous evening.<br><br>The DM indicated all baking pans should be air dried on a drying rack and stacked only after they were completely dry.<br><br>A current policy titled Food Receiving and Storage dated ,d+[DATE] provided by the Administrator on [DATE] at 1:23 PM indicated Food Services or other staff should always maintain clean food storage areas. The policy indicated all food stored in the refrigerator or freezer should be covered, labeled and dated with a use by date.<br><br>A current policy titled Preventing Foodborne Illness- Food Handling, dated ,d+[DATE] provided by the Administrator on [DATE] at 1:23 PM indicated all food service equipment should be sanitized according to current guidelines.<br><br>A current policy titled Dishwashing Machine Use, dated ,d+[DATE] indicated after running items through the dishwasher, the items should be allowed to air dry.<br><br>3XXX,d+[DATE](i)(2)<br><br>3XXX,d+[DATE](i)(3) |