STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Homestead	3136 Goeglein Rd Fort Wayne, IN 46815

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to notify the physician and family timely of a significant change in condition for 1 of 1 residents reviewed (Resident D). Findings include: On 3/11/24 at 10:57 A.M., Resident D's family member/POA (Power of Attorney) was interviewed. The family member indicated the resident had been admitted to the facility following hospitalization for C. Diff colitis (Clostridium Difficile infection of colon). She had completed her therapy and family was waiting until her C. Diff infection was completely resolved to take her home due to home health refusing to provide care at home with an active C. Diff infection. The POA alleged on 12/25/23, another family member had been in to visit the resident. Reidnet D complained of right sided pain in her midsection. The family indicated they did not inform the facility. On 12/27/23, 2 other family members visited and the resident was observed to grab at her right side and stated oh that hurts. Family asked staff to assess the resident and inform the doctor or NP (Nurse Practitioner) of the pain. The staff member was alleged to have put the resident's name on the NP list to be seen at the next scheduled visit. On 12/29/23, a family member contacted the DON (Director of Nursing). The DON indicated she hadn't been aware of the right sided pain Resident D had been having and she was unable to find documentation of the NP visiting her to assess the pain. On 12/31/23, family members came in to visit. Resident D was observed lying in bed, on her right side, in a fetal position. She was lethargic and only responded with mumbles. The family members observed an isolation cart outside the resident's room and asked a CNA (Certified Nurse Aide) why the cart was outside the room. They indicated the CNA hadn't known why the cart was there but thought it was due to the resident having diarrhea. The family asked to speak with the nurse. QMA 2 (Qualified Medication Aid) indicated to the family there was nothing wrong with Resident D. The QMA indicated the resident was having diarrhea and at some point, she was put into isolation. LPN 3 was informed by the family about the concerns with the Resident D's right sided pain, lethargy and diarrhea. The family requested the resident be sent to the hospital for evaluation. The POA indicated the facility hadn't notified the family Resident D was having diarrhea, had been placed in isolation and indicated niether the physician nor the NP were notified of her symptoms until family came in and asked for her to be sent to the hospital. The POA indicated the resident was hospitalized [DATE] until 1/8/24 and hadn't returned to the facility per family's wishes. On 3/12/24 at 10:22 A.M., Resident D's record was reviewed. Diagnoses included Alzheimer's dementia and C. Diff colitis. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission MDS (Minimum Data Set) assessment, dated 11/16/23, indicated the resident had severely impaired cognition. A Discharge Summary, dated 11/27/23, indicated Resident D's expected date of discharge would be 11/30/23 following discharge from therapies. Her diarrhea had improved however, staff reported Resident D had loose, malodorous stools containing mucous, occurring over 11/25/23 through 11/26/23. An order to check for C. Diff was given and a sample was obtained on 11/28/23. The stool culture was positive for C. Diff. Resident D was prescribed a 10 day course of antibiotics beginning 12/4/23. An NP progress note, dated 12/14/23, indicated Resident D had been seen for a post acute care visit. The resident had a history of C. Diff and had been taking Vancomycin (antibiotic) with the last dose scheduled for 12/15/23. She was waiting to go home until her C. Diff infection was resolved as home healthcare wouldn't accept her with an active C. Diff infection. Assessment and Plan indicated C. Diff: resident had a known history of C. Diff and had been on a course of Vancomycin. She would likely undergo testing to assess resolution of the infection. Her return home had been delayed due to concerns from home healthcare about C. Diff infection so ensuring resolution of the infection would be crucial for her transition back home. Staff were to notify the NP of any acute changes in conditions, concerns, or needs. An NP progress note, dated 12/27/23 indicated the resident was seen for chronic care follow up. Resident D's C. Diff infection had resolved on 12/19/23, she had formed stools and was awaiting discharge. Both the resident and staff denied any acute concerns or needs at the time of the visit. The note indicated the resident should continue to be monitored for signs of C. Diff recurrence following completion of antibiotics on 12/15/23. The NP progress note, dated 12/27/23, hadn't indicated the NP was aware of the resident's complaint of right sided flank pain or the family's voiced concerns. Nurse notes, dated 12/31/23 indicated the following: -10:10 a.m., the resident was having mucous like stools which had an odd odor. -2:37 p.m., the resident was resting in bed. She'd had very loose stools with mucous and unusual odor. -3:05 p.m., the family was in and wanted the resident sent to the hospital. The on-call NP was notified and orders given to transport to the hospital for evaluation. Family all came in her room even though was aware of possible C. Diff. On 3/12/24 at 1:25 P.M., QMA 2 was interviewed. She indicated she recalled the resident had complained of back pain but she hadn't observed any obvious injury. She couldn't recall details but indicated if concerns had been reported to her, she would've told the nurse and either she or the nurse would put the request to be seen by the NP in the NP folder for the next visit. She indicated QMA's don't place isolation carts outside resident's rooms as nurses make determinations about isolation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 1:49 P.M., LPN 3 was interviewed. She indicated she was the weekend supervisor who was in charge on 12/31/23. She hadn't put the resident into isolation and assumed Resident D had been placed in isolation the week. She indicated she had been going to notify the family of the resident's loose stools but hadn't had a chance to call either the family or the NP prior to the family's visit. LPN 3 indicated she had not been told Resident D had loose stools or she was in isolation for suspected C. Diff infection. She hadn't recalled the resident complaining of pain however, she had complained of being tired and she had adamantly refused to eat her lunch. On 3/12/24 at 2:30 P.M., the Director of Nursing (DON) was interviewed. She was able to review Resident D's bowel movement chart. The chart indicated the resident had loose stools on day shift on 12/30/23. There was no documentation to indicate the NP or family had been notified. The DON indicated if the resident had been having loose stools and put back into isolation, the doctor or NP and family should've been notified. A current policy, provided by the Assistant Director of Nursing on 3/12/24 at 3:06 P.M. and titled Notification of Changes, stated the following: The purpose of the policy is to ensure the campus promptly informs the residents, consults the resident's physician and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .Circumstances requiring notification include . Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include .clinical complications This tag relates to Complaint IN00429037. 3.1-5(a)(2)