Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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	04/04/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to enure an injury of unknown origin was reported for 1 of 3 residents reviewed (Resident D). Findings include: On 4/4/24 at 1:27 P.M., Resident D's record was reviewed. Diagnoses included dementia with behavioral disturbance. An IDT (Interdisciplinary Team) note, dated 2/26/24 at 11:00 a.m., indicated the resident was observed with swelling and discoloration of the right side of her face. She was not wearing her dentures becasue they were broken. The resident's family was notified of the swelling and broken dentures. The family member indicated too the IDT they were aware of the injury to her face and had taken her to theER on [DATE] to be evaluated and treated. A late entry progress note dated 2/23/24 at 4:00 p.m., indicated the resident's right cheek and side of her face had been swollen without bruising. An IDT note, dated 3/23/24 at 12:27 p.m., indicated Resident D had swelling near and blue bruising below her right eye. She had no signs of discomfort or pain. Staff were interviewed by the facility about the swelling and bruising, but no one knew what had occurred. There was no further documentation in progress or event notes regarding the resident's injuries documentated on 2/23/24 and 3/23/24. There was no investigation into the cause, affect of injury on the resident or follow up for resolution of the injury. In an interview on 4/24/24 at 2:35 P.M., the Director of Nursing (DON) indicated staff had assumed the resident had fallen and had gotten herself back up in both incidents. Staff removed the resident's enabler bars to her bed and her nightstand to prevent fall with injury however, it was unknown whether her injuries were due to falls. She indicated neither she nor the Administrator reported the injuries observed on 2/23/24 or 3/22/24 but should have as the resident was unable to tell staff how they occurred, had no witnessed or reported falls, wasn't prescribed blood thinners, and the injuries had occurred to her face/head. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Compliance with Reporting Abuse, Neglect, Exploitation Policy was provided at 2:37 P. M. by the DON which stated: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources .immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed times .d. Injuries of unknown source: Includes circumstances when both the following conditions are met; The source of the injury was not observed by any person or could not be explained by the resident. The injury is suspicious because of the extent of the injury, location of the injury This tag relates to Complaint IN00431247. 3.1-28(c)