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

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Form Approved OMB
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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	09/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45243 Based on observation, interview, and record review the facility failed to ensure 1 of 5 residents reviewed were free of abuse. (Resident 26). Findings include. Resident 26's record was reviewed 9/17/24 at 2:18PM. Resident 26's diagnoses included dementia, depression, and muscle weakness. A Minimal Data Set (MDS) assessment, dated 8/21/24, indicated Resident 26's Brief Interview for Mental Status score (BIMS) was 3. A score of 3 indicated severe cognitive decline. Section E of MDS indicated Resident 26 had no behavioral symptoms of aggression. Resident 26 was continent of bowel and used a catheter due to urine retention. Resident 26's care plan, dated 9/17/24, indicated he had cognitive loss. Interventions were to allow plenty of time for care, do not rush or push, do not show impatience. Resident 26's care plan, dated 9/17/24, had a problem of argumentative behavior and becoming agitated easily by others. Interventions were to please intervene as needed to ensure safety and the safety of others, please talk with resident in calm manner; do not give directions, do not argue. Resident 26's September 2024 behavior sheet was reviewed. There were 48 documentations missing. There were 3 behaviors being monitored. Anxiety, aggression, and sleep disturbance per shift. Of the 108 documented there were 4 behaviors noted. 2 on 9/16/24 aggression and anxiety and 2 on 9/18/24 aggression and anxiety. The behavior on 9/16/24 was documented as 1st shift. The intervention was documented as redirection and as effective. The behaviors on 9/18/24 were also recorded as 1st shift. The intervention was redirection. The outcome was zero. Resident 26 was observed on 9/17/24 at approximately 10AM, playing bingo in the main activity room. He was sitting at a table with others calmly. Resident 26 was observed on 9/18/24 at approximately noon eating a meal at table with peers talking quietly, no distress noted. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 9/19/24 at 12:17 PM, the video taped footage of an incident between Resident 26 and Qualified Medication Assistant (QMA) 6 on 9/16/24 at 6:18AM was viewed. The video tape showed Resident 26 and QMA 6 at a med cart near the corner of a hall. Talking for several minutes. The resident had no hand gestures, pacing, or other signs of agitation noted. QMA 6 had a relaxed posture. QMA 6 pushed Resident 26 against the wall. Resident 26 walks away and comes back with something in his hand. He approaches QMA 6, they again have a brief discussion. Resident 26 reaches towards her and begins to walk away. QMA 6 then perused Resident 26 reaching around his body and grabbed his glasses from his face while he was in motion. Resident 26 immediately turns back around and begins another discussion. The video then goes to another view of the hall and shows Resident 26 with an arm on QMA 6 and another reaching for something. At the time QMA 6 was up against the wall. QMA 6 then pushes Resident 26 across the entire width of the hall into the opposite wall. Resident 26 falls down the wall onto the ground. Resident 26 loses his shoe during this interaction. QMA then walks away leaving Resident 26 on the ground alone, she looks back states something and walks around the corner. The incident took place on a secured memory care unit. Throughout the video there was another staff member going in and out of rooms on the unit. The other staff member never showed any alarm. There was another resident present who was not interviewable and was unharmed. In an interview, on 9/19/24 at 12:17 PM, the Director of Nursing (DON), indicated her reaction as disbelief and shock. The DON described the footage as QMA 6 pushed Resident 26 against the wall. The DON presented statements from QMA 6 and other staff as part of her investigation of incident. In an interview, on 9/20/24 at 10:06AM, HR (Human Resources) indicated there was a 3.5 min gap missing in the recordings. The view of cameras changed from Hickory Dining to Hickory Living cameras. There was no visualization of QMA 6 or Resident 26 from 6:14:25AM to 6:18:12AM on 6/16/24. The cameras were meant to pick up any motion and record. The HR director indicated the Memory Care Manager (MCM) came to her around 9:30AM and asked to see the videos. Notification was then made to the DON, the Administrator, family, and the Physician An observation of the Hickory Living video, on 9/20/24 at 10:06AM, indicated after the incident, Resident 26 laid on the floor for 5 seconds before gathering his shoe and getting himself up from the floor. A fall statement, dated 9/16/24, indicated Resident 26 was pulling QMA 6's hair and grabbing her. She tripped over own shoes and fell up against wall down to floor while being abused by the resident A statement from QMA 6, dated 9/16/24 at 3:10PM, indicated Resident 26 indicated he was going to walk with her. Resident 26 accused QMA 6 of waking him up. She reminded him when she came to him room, he was on the toilet soiled. He then reminded her she said she would come back, and she did not. He called her an idiot and then spelled it out IDOT (sic). QMA 6 then explained that idiot had 2 I's. He asked for her name. she told him. He returned with a pad of paper and asked her to write it down. He was going to report her. QMA 6 explained she already told him . QMA 6 refused to write her name. Resident 26 grabbed QMA 6's badge. QMA 6 attempted to grab it back. QMA 6 then quickly slid Resident 26's glasses off. He demanded his glasses back. QMA said for the badge. Resident 26 had QMA 6 up against the wall. QMA 6 asked Resident 26 to let her go. Resident 26 refused. An unidentified resident came closer, QMA 6 wrote in her statement a distraction was possible and she pushed Resident 26. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An MCM statement indicated upon arriving for work on 9/16/24, she was met by QMA 6 who requested her to get the badge from Resident 26. The MCM went to Resident 26, he indicated he turned it in downtown. After he felt around for it, he gave it easily to the MCM who gave Resident 26 his glasses. Resident 26 stated, oh there those are. The DON's statement indicated Resident 26 complained of back pain and was given an Xray to rule out any injuries. He also fell a few days prior to the incident, during an activity and had minor complaints then as well. DON indicated disciplinary action was taken for QMA 6. In an interview, , the Maintenance Supervisor indicated the cameras were set to record on movement to allow for longer saving time. Less recording increased ability to save for more days. Maintenance measured the width of the hallway where incident occurred at 7ft. 8 inches. There were no other signs of struggle. No holes in the wall, and no scratches at time of incident to Maintenances knowledge. During an observation, on 9/20/24 at 12:24PM, there were no pictures, fire extinguishers, doors, or other items attached to the walls during observation. In an interview, on 9/23/24 at 9:38A , the Restorative Aid indicated facility training related to abuse indicated staff was never to put hands on a resident.The abuse training module was on the computer. The Restorative Aid indicated the facility did not do any simulated trainings to her knowledge. A policy and procedure titled, Abuse, Neglect, Exploitation Policy dated 9/20/22 last updated 4/23/24 was obtained from DON on 9/23/24 at 9:40AM. The policy indicated . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish It can include verbal abuse, sexual abuse, physical abuse, and mental abuse This Federal Citation is realted to complaint IN00443361. 3.1-27(a)