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	05/07/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37147 Based on interview and record review, the facility failed to ensure a resident was administered medication as ordered by the physician for 1 of 3 residents reviewed (Resident Q). Findings include: On 5/7/25 at 10:45 A.M., Resident Q's record was reviewed. Diagnoses included epilepsy with partial seizures and dementia. A physician order, dated 11/14/25, indicated to give Levetiracetam (anti-seizure medication) 750 milligrams (mg); take 1 tablet by mouth every 12 hours for seizures. A physician order, dated 4/30/25, was to discontinue Levetiracetam 750 mg; take 1 tablet by mouth every 12 hours and start Lacosamide 100 mg tablets; take 1 tablet by mouth 2 times per day for seizures. An Interdisciplinary (ID) note, dated 4/30/25 at 2:05 p.m., indicated Resident Q had gone out for an appointment with the Neurologist. She returned to the facility with new orders to discontinue Levetiracetam and begin Lacosamide 100 mg tablets; take 1 tablet by mouth 2 times per day for seizures. The pharmacy was notified of the change in orders. A Medication Administration Record (MAR), dated May 2025, indicated Lacosamide 100 mg; 1 tablet by mouth 2 times per day was not administered on 5/1, 5/2, 5/3, and 5/4/25. The order was put on the MAR on 5/5/25. Resident Q received the first dose of Lacosamide on 5/5/25 at 9:00 p.m. The MAR, dated May 2025, indicated the resident received Levetiracetam 750 mg 1 tablet by mouth every 12 hours at 9:00 a.m. and 9:00 p.m. on 5/1, 5/2, 5/3, 5/4, 5/5 and 5/6/25 and 9:00 a.m. on 5/7/25. Levetiracetam was not discontinued on 4/30/25 as ordered and was administered without a physician order from 5/1/25 until 5/7/25 after the 9:00 a.m. dose when the error was identified and the medication discontinued as ordered. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 11:17 A.M., Registered Nurse (RN) 9 was interviewed. She indicated when a resident goes out to see a specialist, they should return with a progress note. The note may contain physician orders. When a resident returned from an appointment, the nurse on duty was responsible for reviewing the progress note, noting any new physician orders, transcribing the order onto a physician order form, MAR and notifying the pharmacy of the new medication order. RN 9 had been aware of the new order for Lacosamide and had administered the medication as ordered. She had not been aware the Levetiracetam was to have been discontinued on 4/30/25 and administered the medication as scheduled on the MAR. On 5/7/25 at 12:15 P.M., the Director of Nursing (DON) was interviewed. She indicated the order for Lacosamide was noted and put in place on 5/5/25 when it was discovered the order had not been transcribed onto the MAR nor administered as ordered. She had not been aware of the order to discontinue the Levetiracetam. The Levetiracetam was discontinued and the physician notified as soon as the error was discovered. The facility had no written policy for following physician orders but the DON indicated nurses were expected to follow physician orders as part of the nursing practice. This Citation relates to Complaint IN00457512. 3.1-37

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 37147 Based on interview and record review, the facility failed to ensure a resident's inappropriate touching behavior was identified, prevention interventions implemented and the behavior trended for 2 of 3 residents reviewed for behaviors (Resident D and Resident E). Findings include: Reports, dated 4/12/25 and 4/13/25, alleged Resident D had inappropriately touched a female resident (Resident E) on her legs and chest. Both reports indicated there had been no documented interventions put in place to protect the residents and ensure no further inappropriate touching occurred. The reports alleged there was no documentation in either resident's record regarding the behaviors on 4/7/25. 1. On 5/5/25 at 1:44 P.M., Resident D's record was reviewed. Diagnoses included, Parkinson's, dementia, anxiety, and depression. A quarterly Minimum Data Set (MDS) assessment, dated 2/6/25, indicated a Brief Interview Mental Status (BIMS) assessment indicated Resident D had no cognitive impairment. He had several mood indicators as follows: little interest or pleasure in doing things, feeling down, depressed, hopeless, and feeling tired with little energy. He ambulated short distances without aids and was independent in mobility when using his wheelchair. He was receiving hospice services for end stage Parkinson's disease. A care plan, dated 4/7/25, indicated the resident had socially inappropriate behavior. Interventions included to monitor Resident D's behavior, assist him to determine the cause, intervene as needed to ensure safety of self and others, divert attention, assist to quiet location, modify environment, discuss behavior with him and observe behavioral clues to help understand the behavior. A care plan, dated 2/10/25, indicated Resident D was at risk for adverse effects related to use of a hypnotic for insomnia and anti-depressant medications for depression and anxiety. Interventions were to administer medications as ordered and monitor for adverse effects. The care plan hadn't indicated type of behaviors staff were to monitor for, how often Resident D was to be monitored, nor the type of behavioral clues to help understand the behavior. The care plan hadn't indicated the resident had depression. The care plan hadn't indicated behaviors the resident expressed when feeling depressed or anxious such as fatigue, appetite changes, agitation, expressions of guilt, apathy, anger or acting out towards self or others. Interdisciplinary Notes (ID) indicated the following: -4/3/25 at 11:53 a.m., Resident D was observed sitting in the fireplace room talking with other residents who were not responsive. He held one the resident's hands. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/7/25 at 11:28 a.m., staff reported to the unit manager, over the weekend, Resident D had been feeding his tablemate at meal times. He was observed in his tablemates (Resident F) room, sitting in her recliner, rubbing her shoulders and neck. He had been observed in her room off and on during the morning. -11:42 a.m., Resident D was observed in Resident F's room, standing behind the resident and attempting to lift her up in her wheelchair. Staff spoke with him about not doing this as he or Resident F could hurt themselves. -11:47 p.m., the nurse indicated she had been notified by staff, Resident D had engaged in inappropriate behavior (not documented type of inappropriate behavior) throughout the day. The nurse notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON). -4/8/25 at 3:26 p.m., the hospice case manager was in to visit and reported to the hospice physician, Resident D was having behaviors out of character for him. New orders were given to decrease Resident D's Carbidopa (treats Parkinsons) from every 4 hours to every 6 hours. The physician explained to the hospice case manager, the amount of Carbidopa prescribed may have overstimulated his brain causing a type of psychosis (disconnection from reality). The resident indicated he was feeling down and having family issues at the time. New order given for anti-depressant medication to be given for increased depression and anxiety. -4/9/25 at 3:26 p.m., Resident D had no changes in his condition and remained in his room for the duration of the shift. -10:54 p.m., Resident D had spent a lot of time in his room and hadn't socialized with anyone. -4/14/25 at 1:57 p.m., Resident D had some confusion during the day. At lunch, he spoke of someone coming for lunch but had no visitors. He told the Certified Nurse Aid (CNA) he doesn't know what is wrong with him today. -4/16/25 at 11:22 a.m., the ID team met to review the resident's use of psychotropic medications. Resident D was prescribed Zoloft (anti-depressant), Restoril (for sleep), and Cymbalta (anti-depressant). His dose of Restoril was decreased. There was no documentation of the residents behaviors. A Hospice Plan of Care, updated on 4/14/25, indicated Resident D had been involved in an inappropriate incident at the facility the incident had involved other residents. Support was being provided to the residents family as they dealt with the consequences of the incidents. The resident was on 15 minute watches. The resident had been started on Zoloft on 4/8/25 for inappropriate sexual behavior. His Carbidopa was decreased due to inability to tolerate increased dose for leg pain, stiffness, and spasms. There was no documentation to indicate Resident D had been on 15 minute watches or time frames in which the 15 minute watches had been active. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatric Nurse Practitioner (NP) progress note, dated 4/16/25, indicated Resident D was seen for follow-up psychiatric medication management to assess mood, behavior and efficacy of psychotropic medications prescribed for depression and insomnia. The resident reported his mood was pretty good. He had no signs or symptoms of depression or anxiety and had no reported changes in mood, sleep or appetite. Staff denied any acute concerns. Medication review indicated he was prescribed Carbidopa 5 times per day (every 4 hours). The resident was alert and awake; oriented to person, place and situation; had impaired judgement and insight; flat affect; and no delusions or hallucinations were verbalized. The resident was to continue on his medications for depression and Parkinsons. His medication for insomnia would be decreased. The psychiatric NP progress note hadn't indicated the NP was aware of hand holding observed on 4/3/26 or Resident D's inappropriate touching of female residents on 4/7/25. The progress note hadn't indicated the resident's dose of Carbidopa had been decreased from 5 times per day to 4 times due to psychosis like behaviors observed on 4/7/25. 2. On 5/5/25 at 3:12 P.M., Resident E's record was reviewed. Diagnoses included Lewy body dementia with psychotic disturbance, recurrent major depressive disorder and anxiety. A quarterly MDS assesment, dated 4/11/25, indicated Resident E had severely impaired cognition. She was verbal with clear speech but was rarely understood or able to understand others. She had no mood indicators or behaviors. Resident E was dependent on staff for all activities of daily living (ADL's), was non-ambulatory, had contractures to her legs, and sat in a Broda chair where placed by staff. She was receiving hospice services for end stage dementia. Care plans, with start dates of 4/12/25, indicated the following: -Resident E had periods of restlessness with a recent decline in condition. She was receiving hospice services to aid with care and pain management. She had periods of calling out and being easily distracted. Interventions were to administer her medications as ordered. -Resident E had signs of depression, had multiple losses over the past year and a half including death of husband, decline in health and admission to a nursing home. Interventions included to provide psychiatric services. -Resident E tended to be resistive to care and had behaviors of calling out without a known reason for doing so. She was prescribed anti-depressant medication for depression and anxiety and anti-psychotic medications for Parkinsons psychosis. Interventions included dependent care, hospice care, and inclusion of family with care. ID notes indicated: -4/3/25 at 11:56 a.m., Resident E was seated by the fireplace and was fidgeting with her clothes and blanket. -4/7/25 at 2:45 a.m., hospice services continued. Residnet E had no change of condition observed or reported. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11:33 a.m., Resident E was resting quietly in her broda chair sitting by the fireplace. No changes noted; no verbal/non-verbal signs of pain or discomfort. No changes made to her care plan. -4/8/25 at 4:22 p.m., Resident E had been stable; slept off and on throughout the day; and had no verbal/non-verbal signs of pain or discomfort. -4/9/25 at 3:05 a.m., Resident E continued with hospice services. She had no change in condition and rested comfortably. -10:56 p.m., Resident E was resting quietly in her broda chair sitting by the fireplace. No changes noted; no verbal/non-verbal signs of pain or discomfort. No changes made to her care plan. -4/10/25 at 1:23 p.m., Resident E had no significant changes. She had no verbal/non-verbal signs of pain or discomfort. -4/11/25 at 10:55 a.m., Resident E was seated by the fireplace and was fidgeting with her clothes. She's had no noted changes and no changes to her care plan. -4/15/25 at 12:17 p.m., Resident E and her belongings were moved to a room on another wing. A hospice visit note, dated 4/8/25 at 8:30 a.m., indicated the hospice nurse had been notified by the Unit Manager, another resident had been observed to touch Resident E inappropriately. The other resident was observed to hold Resident E's hand, rub her leg, and was observed putting his hand up her pant leg. There had been no sexual contact made due to presence of resident's incontinence brief and her positioning in the broda chair. The incident was discussed with the DON who reported she and the Unit Manager viewed the camera footage of the incident and there was no sexual contact observed. Resident D was no longer able to go into other resident's rooms and would be closely monitored in common areas. The hospice nurse visited Resident E observed resting comfortably in bed without signs of distress. Resident E was provided a bedbath by the hospice aide. Her skin was observed to be without discoloration or edema. Resident E denied pain and had no signs of increased anxiety. She was unable to recall anything inappropriate or uncomfortable over the past week. On 5/5/25 at 2:54 P.M., Qualified Medication Aid (QMA) 2 was interviewed. She indicated on 4/7/25, she was giving report to the on-coming nurse (Licensed Practical Nurse-LPN 3) at approximately 7:00 p.m. when Certified Nurse Aid (CNA) 4 reported to her and LPN 3, she had just observed Resident D and Resident E in the fireplace room. Resident D had his hand up Resident E's pant leg. CNA 4 reported she moved Resident E to her room and Resident D to his room. QMA 2 left for the evening and on her next scheduled day to work, Resident E had been moved to another wing. QMA 2 indicated she tried to keep Resident D away from the ladies. On 5/5/25 at 3:15 P.M., CNA 4 was interviewed. She indicated on 4/7/25, she had been picking up supper trays when she observed Resident D seated in his wheelchair next to Resident E, seated in her broda chair in the fireplace room. She contined to pick up trays from resident's rooms when she observed Resident D with his hand up Resident E's pant leg. She removed Resident E, took her to her room and left Resident D by the fireplace. She indicated Resident D asked if CNA 4 was going to tell his wife and if what he'd done would be put in the paper. CNA 4 then reported what she had seen to QMA 2 and LPN 3. CNA 4 indicated she had assisted Resident E with putting on her pajamas and hadn't observed any skin issues. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by CNA 5, dated 4/7/25 at 6:47 p.m., indicated she had observed Resident D propel himself into Resident E's room. She went to the room and observed Resident D with his hand on Resident E's chest. Resident D was removed from Resident E's room. There was no cdocumentation of Resident D having his hand on Resident E's chest. On 5/6/25 at 9:45 A.M., CNA 6 was interviewed. She indicated she worked with Resident D daily and had worked with Resident E until she was moved to another wing. She indicated she had never observed him with behaviors of inappropriately touching his peers and it was very surprising. She indicated she had observed Resident D on 4/7/25, in Resident F's room rubbing her shoulders. Resident F was alert and oriented and able to make decisions for herself. She appreciated the shoulder rubbing and indicated liking the attention. CNA 6 reported her observations to the Unit Manager but had not believed it to have been inappropriate. CNA 6 indicated Resident D liked to visit a resident on another wing and would get all spiffed up before going to visit. She was not aware of who the resident was, only he had a friend he liked to visit. Resident D was independent in mobility in his wheelchair and was able to visit other wings of the facility as desired. A CNA work sheet, dated 4/29/25, had not indicated any behavior interventions were in place to monitor Resident D's visits with other female residents. On 5/6/25 at 10:22 A.M., CNA 7 was interviewed. He indicated Resident D used to come over on his wing to visit with Resident X in her room but hadn't done so recently due to Resident D's spouse's wishes. He indicated Resident E resided on the wing but Resident D had not been observed visiting her room. On 5/6/25 at 11:32 A.M., the DON was interviewed. She provided a copy of her investigation of the 4/7/25 incident between Resident D and Resident E. She indicated Resident D had resided in the facility for over a year and she had not been informed of behaviors related to inappropriately touching female residents. He had been having odd behaviors described as inattention, difficulty focusing, looking above her when speaking to him, not making eye contact, and seeming out of touch with reality. She had been notified of the incident and the Unit Manager had come to the building to investigate. LPN 3 had been instructed to put the resident on 15 minute checks and keep a close eye on Resident D. The DON indicated on 4/8/25, she and the Unit Manager viewed the camera footage of the incident and observed the resident holding Resident E's hand and then rubbing her arm and knee and placing his hand under her pant leg where he rubbed her leg. Resident E's family was notified of the incident. She indicated Resident E was moved to another wing per family request. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 10:15 A.M., the Social Services Director (SSD) was interviewed. She indicated she and her assistant managed behaviors in conjunction with the ID team and psychiatric NP. She indicated she gets notified of a new behavior through an alert documented on a paper form and given to her or her assistant. The care plan and behaviors were then reviewed and changes made as required. She had no precise knowledge of the incident between Resident D and Resident E, had been unable to find documentation her assistant had been made aware of and followed up on the incident. The care plan had not been updated with specific behavioral interventions related to the incident, how to prevent further recurrence and protect residents involved or other residents with the potential to be affected. The SSD provided a copy of Resident D's monthly behavior monitoring flowsheet for April. She indicated the flowsheets were used for psychotropic medication reviews. Targeted behaviors being monitored for Resident D was insomnia and depression. The flowsheet had not indicated how Resident D expressed depression such as sad face, decreased appetite, anger with spouse, verbalizing hopelessness, changes in sleep, inappropriate touching, etc. On 5/7/25 at 12:57 P.M., the DON provided a current copy of the facility policy, titled Behaviorial Health Services-Social Services, which stated: It is the policy of this community to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning .The community utilizes the comprehensive assessment process .The assessment and care plan will include goals that are person centered and individualized .Monitor the resident closely for expressions or indications of distress. Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate the change in behavior was unavoidable .Share concerns with the ID team to determine underlying causes of mood and behavior changes .Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record. Ensure appropriate follow-up assessment This Citation relates to Complaints IN00457494 and IN00457512. 3.1-37

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37147 Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 of 3 residents reviewed (Resident D and Resident E). Findings include: Reports, dated 4/12/25 and 4/13/25, alleged Resident D had inappropriately touched a female resident (Resident E) on her legs and chest. Both reports indicated there had been no documented interventions put in place, following the alleged incident, to protect the residents and ensure no further inappropriate touching occurred. The reports alleged there was no documentation in either resident's record regarding the incidents on 4/7/25. 1. On 5/5/25 at 1:44 P.M., Resident D's record was reviewed. Diagnoses included, Parkinson's, dementia, anxiety, and depression. An Interdisciplinary (ID) note, dated 4/7/25 at 11:47 p.m., indicated the nurse had been notified by staff, Resident D had engaged in inappropriate behavior throughout the day. The nurse notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON). An ID note, dated 4/8/25 at 3:26 p.m., indicated the hospice case manager had spoken with the hospice physician and reported the resident was having behaviors out of character for him. The ID notes, dated 4/7 through 4/8/25, hadn't indicated what inappropriate behaviors the resident was having, who was affected by the behaviors and interventions taken by the facility to address the behaviors. A Hospice Plan of Care, updated on 4/14/25, indicated Resident D had been involved in an inappropriate incident at the facility which involved other residents. The resident was on 15 minute checks. There was no documentation of the resident being on 15 minute checks when inappropriate behaviors were observed on 4/7/25. There was no documentation of 15 minute checks being completed when the hospice plan of care was updated on 4/14/25. A psychiatric Nurse Practitioner (NP) progress note, dated 4/16/25, indicated Resident D was seen for follow-up psychiatric medication management to assess mood, behavior and efficacy of psychotropic medications prescribed for depression and insomnia. Staff denied any acute concerns. Medication review indicated he was prescribed Carbidopa 5 times per day (every 4 hours). The psychiatric NP progress note hadn't indicated the NP was aware of the incidents of inappropriate touching on 4/7/25. The progress note hadn't indicated the resident's dose of Carbidopa had been decreased from 5 times per day to 4 times due to psychosis like behaviors observed on 4/7/25. 2. On 5/5/25 at 3:12 P.M., Resident E's record was reviewed. Diagnoses included Lewy body dementia with psychotic disturbance, recurrent major depressive disorder and anxiety. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ID note, dated, 4/7/25 at 2:45 a.m., indicated hospice services continued for Resident E and she had no change of condition observed or reported. The ID note hadn't indicated the resident had been observed to be touched inappropriately by Resident D. There was no documented notification to the physician or family. There was no skin assessment completed immediately to check for injury due to the contact nor documentation of how the resident was being kept safe through the night until further assessment could be completed and the care plan updated. A hospice visit note, dated 4/8/25 at 8:30 a.m., indicated the hospice nurse had been notified by the Unit Manager, another resident had been observed to touch Resident E inappropriately. The other resident was observed to hold Resident E's hand, rub her leg, and was observed putting his hand up her pant leg. There had been no sexual contact made due to presence of resident's incontinence brief and her positioning in the broda chair. The incident was discussed with the DON who reported she and the Unit Manager viewed the camera footage of the incident and there was no sexual contact observed. The other resident was no longer able to go into other resident's rooms and would be closely monitored in common areas. The hospice nurse visited Resident E who was observed resting comfortably in bed without signs of distress. Resident E was provided a bedbath by the hospice aid and her skin observed without discoloration or edema. Resident E denied pain and had no signs of increased anxiety. She was unable to recall anything inappropriate or uncomfortable over the past week. The hospice visit note hadn't indicated how Resident D was no longer able to go into other resident's rooms. There was no documentation in the clinical record for either Resident D or Resident E to indicate the DON and Unit Manager had conducted to rule out no sexual contact had occurred. Neither resident's record indicated families were notified of the incident nor interventions put into place to keep each resident safe. On 5/6/25 at 11:32 A.M., the DON was interviewed. She provided a copy of her investigation of the 4/7/25 incident between Resident D and Resident E. She had been notified of the incident and the Unit Manager had come to the building to investigate on 4/7/25. The nurse in charge, who reported the incident, had been instructed to put the resident on 15 minute checks and keep a close eye on Resident D. There was no documentation to indicate this had been implemented. On 5/7/25 at 4:34 P.M., the DON provided a current copy of the facility policy, titled Documentation in the Medical Records which stated: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .Licensed team members and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record at the time of service, but no later than the shift in which the assessment, observation, or care service occurred This Citation relates to Complaints IN00457494 and IN00457512. 3.1-50(a)