

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Golden Years Homestead		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure allegations of verbal abuse and mistreatment were reported to the Administrator and state agency within required timeframes for 3 of 5 residents reviewed (Resident B, Resident D, and Resident H). Findings include: A report, dated 6/29/25, alleged Resident B and Resident H were involved when Certified Nurse Aid (CNA) 5 had yelled at the residents and not provided care according to their individual care plans. The report alleged the incidents had been reported to management, but nothing had been done. The report indicated Resident D had alleged physical abuse, reported to Human Resource staff instead of the Administrator or Director of Nursing (DON) per facility policy, and no investigation had allegedly been done. 1. The report, dated 6/29/25, alleged on 5/26/25, Resident B had wanted to have his brief changed and had been trying to get staff's attention. He had been seated in his wheelchair next to his bed. His call light was on the other side of the bed and out of his reach. Employee 2 indicated they had observed the call light out of the resident's reach, had turned the call light on and placed it on his overbed table in front of him. Approximately, 1 and 1/2 hours later, Employee 2 returned to check on the resident. He indicated staff had not come to help him although his call light was turned off. Employee 2 turned the call light on again, verified it was on and working correctly, and told the resident they would be back to check on him. A half hour later, Employee 2 returned, observed the call light off and the call light moved out of the resident's reach. Resident B indicated staff had not yet assisted him to change his brief. Employee 2 summoned their supervisor (Employee 3) who went to the resident's room and waited for staff to provide the resident assistance. Employee 3 indicated they would report the incident. On 7/16/25 at 12:43 P.M., Resident B's record was reviewed. Diagnoses included Parkinson's disease and dementia. A quarterly Minimum Data Set (MDS) assessment, dated 5/23/25, indicated the resident had no cognitive impairment. He had no behaviors or indicators of delirium. He required partial to maximal assistance with his activities of daily living (ADL) due to his Parkinson's disease symptoms. Care Plans indicated: 5/26/25-Resident B required assistance with his ADL's and was able to make his needs known without difficulty. Interventions included: assist with dressing, toileting and transfers; and encourage the resident to use the call light to ask for assistance. 5/26/25-The resident was incontinent of bowel and bladder and required assistance with incontinent care; he could usually recognize the urge to toilet but required assistance with toileting. Interventions included: change incontinent briefs frequently and assist to toilet frequently. On 7/16/25 at 11:05 A.M., Resident B's spouse was interviewed. She indicated she came to the facility every other day for long periods of time. When asked about staff, she indicated Resident B had multiple issues with CNA 5 for some time and had reported her last fall. She believed care from CNA 5 had improved but remained concerned with the call light placement and it not being placed within the resident's reach. She had witnessed this several times when CNA 5 cared for him. She indicated the resident was becoming more fearful due to increasing dependency from Parkinson's disease and he needed to have access to the call light to summon help from staff. On 7/16/25 at 1:56 P.M., the Clinical Nurse Leader (CNL), for the unit where all 3 residents resided, was interviewed. She indicated she had been made aware of resident's complaints about CNA 5. She spoke with CNA 5 about resident care but hadn't reported the complaints to the DON. When asked, the CNL indicated putting a resident's call light out of their reach or yelling at resident's could be considered abuse and she should have reported it. On 7/16/25 at 3:50 P.M., Employee 2 was interviewed. The employee indicated they had reported the concerns to the CNL due to the seriousness of resident's complaints and alleged lack of follow up. The employee indicated Resident B and his spouse had reported, CNA 5 had a rectangular shaped device in her pocket, pulled partly out and shown to the resident. CNA 5 allegedly told Resident B, they were recording him so he couldn't say anything about the CNA. On 7/17/25 at 10:45 A.M., Resident B was interviewed. He indicated having issues with CNA 5. The CNA was temperamental and never knew what kind of mood she would be in. He indicated approximately 1 month ago, CNA 5 had gotten really angry with him, had pulled his call light out from the socket and threw it against the wall. Around the same time, the CNA had shown him a device in her pocket and said she was recording him so he couldn't say things about her. He indicated there were times when CNA 5 would turn off his call light and leave the room without helping him or would place his call light out of his reach so he couldn't call for help. When questioned, he indicated he had not reported the incident with the recording device as he hadn't wanted the CNA to get mad at him. On 7/17/25 at 11:06 A.M., in an interview, Employee 3 indicated on 5/26/25, Employee 2 had reported Resident B had his call light turned off</p>		