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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45243 Based on observation, interview, and record review the facility failed to ensure interventions were implemented to prevent feelings of fear for 1 of 2 residents reviewed. (Resident 3) Findings include: In an interview, on 9/17/24 at 11:09AM, She indicated she had been overwhelmed since her husband's passing in May 2024. Resident 3 pointed to several boxes against the wall across from her bed of memorabilia she felt responsible to sort and disperse to family members. Resident 3 explained her diagnosis of PTSD realted to sexual, verbal, and physical abuse as a child. Resident 3 indicated the only times she was triggered in the facility was when a peer (Resident 85) was coming into her room uninvited especially at night. Resident 3 described a male peer coming into her room sometimes making it to the foot of her bed before she would see him or feel him looking at her. Resident 3 reported she would be the one to alert staff to his continued unwanted presence in her room, and he would be redirected back to his room. After several incidents, more than 5 times of redirecting peer back to his room, the Resident 85 was moved to another room and the visits stopped. Resident 3 indicated no other solution was given to her or offered. The facility placed no stop signs on her door, no net was placed to deter the peer. Resident 3 requested to be able to lock her door and was told that was not allowed for safety concerns. Resident 3 indicated she felt safe at this time. Resident 3 indicated Resident 85 never got far enough to do anything physically to her but she felt very anxious and extremely uncomfortable in the situation. During an observation, on 9/17/24 at 11:09AM, Resident 3 was observed to be tearful. Resident 3's record was reviewed on 9/18/24 at 10:59AM. Diagnoses included anxiety, depression, and post traumatic stress disorder. A Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Brief Interview of Mental Status (BIMS) score was 15. A score of 15 indicated no cognitive decline. Section D for mood indicated Resident 3 had difficult falling, staying, or sleeping too much nearly every day. Section E for behaviors indicated Resident 3 had no behaviors. Monthly Behavior Monitoring Flowsheets were reviewed, dated August 2024. No incidents of behaviors were recorded. The behaviors being monitored were mood disorders, depression, and insomnia. August 23 was without documentation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monthly Behavior Monitoring Flowsheets were reviewed, dated September 2024. No incidents of behaviors were recorded. The behaviors being monitored were mood disorders, depression, and insomnia. Resident 3's Brief Trauma Questionaire was not dated. The DON dated it for the date of admission. The DON indicated no other trauma assessment was performed. In the questionnaire it was identified Resident 3 had trauma related to the following: Accident were she was seriously injured, a life threatening illness and cancer, before age 18 was physically punished and would feel threatened or in danger. and was pressured into having unwanted sexual contact and would feel in danger. A Care Plan, dated 6/3/24, indicated a problem of mood state, signs of depression, diagnoses of anxiety, depression, personality disorder, PTSD (post traumatic stress disorder). The goal was the resident would like her mood to improve. Interventions were as follows: administer medications as ordered, schedule psych eval and follow any treatment recommendations, and provide an opportunity to vent issues. There was no trauma specific problem in the care plan. No goal made for trauma needs. There were no interventions or triggers identified. A care plan, dated 9/20/24, included a problem of trauma. The problem indicated a potential for mood disturbance related to history of childhood trauma- moved on and healed from traumatic events in their life and denies having any triggers for remininscing. The goal indicated the resident would be able to verbalize if they become triggered and remembering past events through next review. The interventions were as follows: Observe for non verbal cues regarding traumatic events Offer resident safe place to vent feelings Encourage resident to participate in activities of enjoyments such as Offer psych services if willing to participate A physician note, dated 8/26/24, indicated Resident 3 had an acute complaint of a male peer coming into her room. Resident 3 was given PRN hydroxyzine every 8hrs and details were discussed with social services. A policy and procedure titled, Trauma Informed Care dated 11/2019, last updated 8/21/2024 was provided by DON on 9/19/24 at 2:16PM. The policy indicated .provide care and services account for experiences and preferences, and address the needs of trauma survivors by minimizing triggors and/or retraumatization .d. physical, sexual, mental, and/or emotional abuse (past or present). i. Traumatic life events (death of a loved one, personal illness, etc) a. safety. Ensuring residents have a sense of emotional and physical safety. d. empowerment. voice. and choice. 7. Trauma specific care plan will interventions will recognize the interrelationship between trauma and symptoms of trauma.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44531 Based on observation, interview and record review, the facility failed to ensure medications were dated when opened, and destroyed when expired in 2 of 4 medication carts. Findings include: During an observation, on [DATE] at 1:36 PM, with License Practical Nurse (LPN) 4 on the D hall medication cart, Trelegy 100/ 62.5, inhaler was without a box and no open date for Resident 47. LPN 4 indicated medication should not be in the cart without the date. During an observation on [DATE] at 1:50 PM, with Qualified Medication Aide (QMA) 5 on C hall medication cart, there was an open bottle of Nystatin [NAME] 100 mg with no open date for Resident 27. On the second medication Cart on C hall with QMA 5, was a bottle of Lidoncaine Sol 2% oral with no open date for Resident 25. In the same medication cart, was the medication Insulin Lispro INJ 100 U with an open date of [DATE] and an expiration date of [DATE] for Resident 37. In the same drawer there was a medication of Lantus INJ 100 U with an open date of [DATE] and expiration date of [DATE] for Resident 13. 1. A record review for Resident 47 on [DATE] at 9:05 AM. Diagnoses included, Chronic Pulmonary Disease unspecified. A review of the Physician orders indicated to give Trelegy Ellipta 100 mcg (microgram)-62.5 mcg- 25 mcg powder for inhalation (Fluticasone-umecclidin-vilanter) inhale 1 puff daily at noon, rinse mouth with water after use- 1 puff inhalation every day for chronic pulmonary disease with a start date of [DATE]. A review of the medication administration record (MAR), dated [DATE], indicated Trelegy Ellipta was given on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17. There was no open date for this medication. 2. A record review of Resident 27, on [DATE] at 9:35 AM. Diagnoses included, Alzheimer's disease with late onset. A review of the physician orders indicated there were no active orders for the Nystatin [NAME] 100. 3. A record review of Resident 25, on [DATE] at 9:45 AM. Diagnoses included, Chronic Obstructive pulmonary disease. A review of the physician ordersindicated to give Lidocaine 2% mucosal solution (generic) 15 milliliter (ml). Swish and spit every 8 hours before meals. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR, dated [DATE], indicated Lidocaine 2% solution was given on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17. There was no open date for this medication. 4. A record review of Resident 37, at [DATE] at 10:05 AM. Diagnoses included, Type 2 diabetes mellitus. A review of the physician orders indicated to give Humalog U-100 insulin 100 units/ml-subcutaneous solution (insulin lispro)- 2 units subcutaneous three times a day for diabetes with each meal, and Insulin lispro (U-100) 100 unit/ml subcutaneous solution (generic)-100 unit/ml: give 2 units- 201 through 250 4 units- 251 through 350 6 units- 351 through 400 A review of the MAR, dated [DATE], indicated Insulin lispro was given on the following dates: 17. The medication had expiration date of [DATE]. 5. A record review of Resident 13 at [DATE] at 10:25 AM. Diagnoses included, Type 2 diabetes mellitus. A review of the physician orders indicated to give Lantus INJ 100/ml-inject 50 units subcutaneous daily. A review of the MAR, dated [DATE], indicated Lanuts INJ 100 units was given on the following dates: 15, 16, and 17. This medication had a expiration date of [DATE]. A current facility policy, Medication storage Policy, dated [DATE], was provided by the Director of Nursing on [DATE] at 8:51 AM. The policy indicated . it is the policy of this facility to ensure all medications housed on out premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security 3XXX,d+[DATE](j)(m) and (n)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45243 Based on observation, interview and record review the facility failed to ensure infection control measures were maintained for oxygen tank tubing for 2 of 3 residents reviewed. (Resident 16 and Resident 247) During an observation, on 9/17/24 at 12:20 PM, there were 2 oxygen tanks in the hallway on the floor. The tubing for both tanks were observed to be wrapped around the hand rail outside of the beauty shop. There were no covers, any bags, or dates observable for the tubing to be placed into. In an interview, on 9/17/24 at 12:25 PM, the Director of Nursing (DON), indicated the resident would wear their oxygen to the beauty shop and leave the tank outside. 1. A record review of Resident 16 was completed on 9/17/24 at 1:05 PM. Diagnosis included, chronic obstructive pulmonary disease. A physician order for Oxygen 2 liter (L)/ min, indicated to give nasal oxygen every shift for chronic obstructive pulmonary disease with (acute) exacerbation. 2. A record review of Resident 247 was completed on 9/17/24 at 1:05 PM . Diagnosis included, dependence on supplemental oxygen. A physician order of Oxygen- 2L/min indicated to give nasal oxygen every shift for chronic obstructive pulmonary disease. In an interview, on 9/19/24 at 9:00 AM, DON indicated the facility did not have a current facility policy. 3.1-18(a)