

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: 155756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Coventry Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W Jefferson Blvd Fort Wayne, IN 46804	
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. 37147 Based on interview and record review, the facility failed to ensure a resident's right to be free from physical abuse was protected for 1 of 3 resident's reviewed (Resident B). The deficient practice was corrected on 10/24/24 prior to the start of the survey and was therefore past non-compliance. Findings include: An Indiana Department of Health (IDOH) incident report, dated 10/22/24 at 6:20 p.m., indicated the Administrator had been notified, Certified Nurse Aid 5 (CNA) had made contact with Resident B while he had been combative with staff. The resident's safety had been insured and he was provided quiet space. CNA 5 was immediately sent home and removed from the schedule pending investigation. On 11/6/24 at 11:06 A.M., Resident B's record was reviewed. Diagnoses included severe dementia with behavioral disturbance, mood disorder, and restlessness and agitation. A quarterly Minimum Data Set (MDS) assessment, dated 10/7/24, indicated the resident had severely impaired cognition. He required moderate to fully dependent care from staff for his activities of daily living. He resided on the secured memory care unit and was prescribed a mood stabilizer for his behaviors. A care plan, revised 10/15/24, indicated the resident had behavioral symptoms. He would hit staff when care was being provided and at times, had episodes of kicking, hitting, and grabbing staff's arms and fingers during care. The goal was for his behaviors to be altered with staff interventions. Interventions were: notify spouse to bring photo of herself to help calm him when he was agitated; allow resident time to calm; attempt care at a later time and with different care giver; and observe for indicators of pain. A care plan, revised 10/15/24, indicated the resident displayed anxious behaviors and at times, would try to hit staff when told to sit down so he wouldn't fall. Interventions were: offer to lay down; medication per order; assist him to go for a walk when he appeared anxious and was attempting to stand on his own; assist him with activities of his interest as a distraction-he liked listening to oldies, eating snacks, and being outdoors; talk calmly to the resident and explain to him to sit down so he doesn't fall and redirect. (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	On 11/6/24 at 1:48 P.M., the Administrator was interviewed. She indicated, on 10/22/24, she had been notified by a staff member, they had witnessed an event. The Resident B had been agitated and hit CNA 5. CNA 5 then struck Resident B with an open hand on the back of his right shoulder while he was seated in the dining room. The Administrator came to the building, interviewed CNA 5 who indicated she was assisting the resident to eat dinner when he had punched her in the stomach. She swatted him back as a reflex but had not intended to harm the resident. CNA 5 was suspended pending investigation. Resident B was assessed, found with no injury, and was monitored for psychosocial distress. The Administrator interviewed witnesses and reviewed video recording of the incident. A thorough investigation was conducted. This included skin assessments, interviews of residents on the memory care unit, staff interviews, and family member interviews who were frequent visitors to the unit. All staff were re-educated on managing aggressive behaviors and abuse and on 10/24/24. A current facility policy, titled Abuse Prohibition, Reporting, and Investigation, was provided by the Administrator on 11/6/24, and indicated: It is the policy to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion The past non-compliance deficiency began on 10/22/24 and deficient practice corrected on 10/24/24 after the facility suspended and then terminated CNA 5's employment and reported the incident to IDOH as required. Resident B was immediately assessed for injury and monitored for psychosocial distress related to the incident. The facility completed education with staff on managing aggressive behaviors and abuse. This Citation relates to Complaint IN00445849. 3.1-27(a)(1)		