

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 03/04/2026
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review the facility failed to ensure staff were present during a change of condition to prevent a fall for 1 of 3 residents reviewed (Resident B). Findings include: A fall investigation file was provided by the Assistant Director of Nursing (ADON) on 3/4/26 at 9:45 AM. The file included the following: A report, dated 2/9/26, indicated Resident B was assisted to the toilet by a Certified Nursing Assistant (CNA) and began to vomit. The report indicated the aide left Resident B on the toilet alone and went to get assistance from the nurse. Upon return the nurse and CNA found Resident B face first on the floor with a laceration to the right side of Resident B's head. Resident B indicated he passed out and didn't remember what happened. The report indicated Resident B was sent to the hospital. A fall event report, dated 2/8/26 at 10:46 AM, indicated Resident B had an unwitnessed fall. The report indicated Resident B was found lying on the bathroom floor on his stomach with his head facing the wall. A fall investigation report, undated, indicated on 2/8/26 Resident B had an unwitnessed fall in the bathroom. The resident had been assisted to the bathroom by a CNA and began to vomit along with diarrhea. The report indicated the aide left Resident B on the toilet and went to get the nurse for assistance. Upon return the nurse and CNA found Resident B lying on the bathroom floor on his stomach with his head facing the wall. The report indicated Resident B indicated he passed out and didn't remember what happened. The report indicated Resident B had a laceration to the right side of his head with vomit present on the floor. The report indicated Resident B required assistance with a wheelchair. Resident B's record was reviewed on 3/4/26 at 9:30 AM. Diagnoses included amputation to left great toe, chronic kidney disease, asthma, hypertension and anemia. An admission fall risk assessment, dated 1/14/26, indicated Resident B was at moderate risk for falls. An admission care plan, dated 1/14/26, indicated Resident B was at risk for falls and required assistance or supervision for mobility, transfer or ambulation. An admission Minimum Data Set (MDS) assessment, dated 1/14/26, indicated Resident B had a Brief Interview Mental Status score of 15/15 (cognitively intact). An admission functional abilities collaboration report, dated 1/14/26, indicated Resident B needed partial to moderate assistance with toileting and transferring. A nursing note, dated 2/6/26, indicated Resident B participated in therapy and required 1-2 person assistance with transfers. A nurse practitioner note, dated 2/2/26, indicated Resident B tested positive for Clostridioides difficile (C-Diff) on 1/30/26 and an antibiotic was started. The note indicated Resident B's labs were monitored and intravenous fluids were administered. A nurse practitioner note, dated 2/8/26, indicated Resident B reported improvement in loose stools and the labs were improving. The note indicated the resident denied any nausea nor vomiting at the time of the visit. An interdisciplinary note, dated 2/8/26, indicated Resident B had been assisted to the toilet by a CNA and began vomiting. The note indicated CNA left Resident B alone on the toilet and left to get assistance from the nurse. The note indicated upon return the nurse found the resident had fallen off the toilet and was face first on the floor with blood pooling from the right side of his head. The note indicated Resident B indicated he did not remember what happened. The note indicated prior to the fall the resident was last assisted at 10 AM to the toilet. Emergency Department medical records from an area hospital, dated 2/10/26, indicated Resident B was transferred to the hospital on 2/8/26 (continued on next page)</p>

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>due to a fall off the toilet at the facility. The records indicated the cause of the fall was due to hypovolemia (dehydration) and vasovagal response (fainting). During an interview, on 3/4/26 at 10:21 AM, CNA 3 indicated when the resident had a change of condition, such as vomiting, while on the toilet, the aide should never leave the resident. CNA 3 indicated the call light should be activated or call out for the nurse should be completed. CNA 3 indicated when an aide left the resident on the toilet after vomiting, the resident could fall. During an interview, on 3/4/26 at 10:23 AM, Licensed Practical Nurse (LPN) 4 indicated when a resident had a change of condition, such as vomiting while on the toilet, the aide should never leave the resident. LPN 4 indicated the aide should call out for help or activate the call light. During an interview, on 3/4/26 at 10:50 AM, the ADON indicated Resident B experienced diarrhea due to C-diff but the vomiting was new as of 2/8/26. The ADON indicated staff left residents alone on the toilet when the staff felt the residents were safe. A policy, last revised 6/25, titled Fall Management Policy, was provided by the ADON on 3/4/26 at 11:11 AM. The policy indicated all new admission residents are considered a fall risk due to the new environment. This citation relates to Intakes 2740759 and 2739739.483.25(d)(1)(2)- 3.1-45(a)</p>		