STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry Meadows	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure a follow up to an unwitnessed fall was completed for 1 of 1 residents reviewed. (Resident 3)Findings include:A record review began on 7/21/25 at 10:32 AM, Resident 3's diagnosis included, other cerebral infarction due to occlusion or stenosis of small artery.A review of progress notes dated 4/19/25 at 2:54 PM, indicated Certified Nursing Aide (CNA) 6 reported to writer, Resident 3 was lying on the floor mat. She noted a right wrist purple bruise, assisted resident back to bed with help from 3 staff. The immediate intervention initiated was to encourage Resident 3 to use the call light for assistance. A review of event report, dated 4/19/25 at 2:50 PM, indicated a new skin event for right wrist bruising was completed.There were no other events or reports completed for this unwitnessed fall.In an interview on 07/23/25 at 12:05 PM, the Director of Nursing (DON) indicated they are unable to locate a fall event or any information regarding the fall. The DON indicated they were unable to locate neurological checks or any other assessments related to the fall. A current facility policy, titled Fall Management Policy, dated 3/24, was proved by the DON on 7/24/24 at 10:28 AM. The policy indicated . A fall event will be initiated as soon as the resident has been assessed and cared for .The report will be completed in full to identify possible root cause of the fall and provide immediate interventions 3.1-45(a)

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