STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COVENTRY MEADOWS, L.L.C.	7833 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00460522. Complaint IN00460522 - Deficiencies related to the allegation are cited at R0053. Survey date: June 18, 2025 Facility number: 005846 Residential Census: 74 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 18.2025	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency Based on interview and record review, the facility failed to ensure resident was free from verbal abuse for 1 of 1 residents reviewed (Resident K). Findings include: An Indiana report form, submitted by the facility, on 5/29/25 at 4:05 PM., indicated License Practical Nurse (LPN) 4 was heard using curse words while having a conversation with Resident K. On 6/18/25 at 10:58 AM., Resident K's record was reviewed. Diagnoses included Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.	R 0053	Employee was terminated on 5/29/25 following immediate suspension of allegation. Resident has been free of psychosocial distress since incident. All residents have the potential to be affected. Resident interviews were conducted with no other findings related to abuse by staff or other persons. All staff abuse reeducation and inservice by 7/16/25 including resident rights, abuse policy and reporting. Reeducation and inservice to be completed with all staff. Abuse	07/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Owens	Executive Director	07/07/2025

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	An Investigation Summary Report, provided by the Administrator on 6/18/25 at 9:33 AM, Qualified Medication Aide (QMA) 6 indicated she witnessed LPN 4 verbally abuse Resident K on 5/28/25 about 5:00 PM. QMA 6 indicated Resident K was leaving the dinning room and observed him approaching LPN 4 regarding his medication. LPN 4 then indicated, " what did I f*** up again... Well when was the first time I f***** up... When were the other times I f***** up?" Resident K, ended up walking away. QMA 6 later went to his room, to see if the LPN had talked to him using profanity, becasue she had only seen the back of his head. QMA 6 asked him what was said and Resident K indicated he asked LPN 4 if she could correct his medication, he said it was not the first time he made the rquest. QMA 6 indicated the way LPN 4 was speaking at him and cussing at him was too aggressive and disrespectful. A written statement was reviewed, dated 5/28/25, by the Business Office Manager and Memory Care Social Services. An interview with Resident K indicated he went to dinner and sat down. LPN 4 came in and sat his pills down but didn't say a word to him. He had been waiting for his insulin so he could eathisy supper. Eventually, the Memory Care nurse came and gave him his insulin. Resident K let her know he only had 3 pills and he usually took 5 pills in the evening. The Memory care nurse went and got the rest of his medication. When he was done eating, he walked out to the hallway. LPN 4 was standing there and started cussing at the resident. She said some not very nice words. She used more then one cuss word too. Resident K then indicated, the nurse from the other hallway over-heard LPN 4's inappropriate conversation, came down to his apartment to apologize and indicated she would report it to the supervisor.		reporting monitoring tool will be used weekly x 4 weeks and monthly x 2 months. Abuse policy monitoring tool will be conducted by ED or designee. If 100% threshold is not met a new action plan or disciplinary action will be completed. Tool will be reviewed in QAPI meeting Systemic changes will be completed by 7/16/25	

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	A written statement, dated 5/29/25, by LPN 4 indicated there was no due process of first allegation of swearing on 5/21/25. The second allegation had no explanation, the facility did not tell me who, what I said, to whom I said it to, or what time I allegedly said it. The facility would not state if she was suspended with or without pay. The facility gave no detail of the incident, but told me the last incident was false. LPN 4 did not agree as this allegation was false. In an interview, on 6/18/25 at 9:43 AM, Resident K indicated it was the first time LPN 4 ever cursed at me or did anything like that to me. The resident was just coming out of the dinning room, and she called him "M*****F*****", another nice nurse heard her. Resident K indicated he didn't feel unsafe at the facility, he has had great aids that helped him. He has had issues with LPN 4, regarding his medications being messed up and he went to the Administrator to let her know about them. A Current facility policy, titled Abuse Prohibitation, reporting, and investigation dated 6/2023. Was provided by the Administrator on 6/18/25 at 9:33 AM. The policy indicated..." Verbal Abuse-the use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. This includes any episode of staff to resident, and verbal threats of harm by resident to resident. This does not include random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language...." This citation relates to Complaint IN00460522.			

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