PRINTED: 07/07/2023
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED
		155364	B. WING		06/16/2023	
					00, 10,	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD		
	no viben on borrein.		1661 B	EACON STREET		
BYRON	HEALTH CENTER		FORT \	WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
F 0000						
Bldg. 00						
	This visit was for a	Recertification and State	F 0000			
	Licensure Survey.	This visit included the				
		omplaint IN00410050. This visit				
	-	te Residential Licensure				
	Survey.					
	Survey.					
	Complaint IN0041	0050 no deficiencies were cited.				
	Complaint 11 (00 11)	0050 no deficiencies were effect.				
	Survey dates: June	12, 13,14,15, and 16, 2023.				
		222				
	Facility number: 00					
	Provider number: 1					
	AIM number:1002	73280				
	Census Bed Type:					
	SNF/NF:100					
	Residential:48					
	Total:148					
	10tal:146					
	Census Payor Type	:				
	Medicare:3					
	Medicaid:142					
	Other:3					
	Total:148					
	104411110					
	These deficiencies	reflect State Findings cited in				
	accordance with 41					
	accordance with 41	10 IAC 10.2-3.1.				
	Quality raviasy con	npleted June 21, 2023				
	Quality review con	ipieted Julie 21, 2023				
F 0684	483.25					
SS=D	Quality of Care					
Bldg. 00		of coro				
Diag. 00	§ 483.25 Quality					
		a fundamental principle that				
		tment and care provided to				
	facility residents.					
	comprehensive a	ssessment of a resident, the				
i e	1		1	i e		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Sarah Starcher Executive Director/COO 07/06/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/16/2023 155364 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1661 BEACON STREET BYRON HEALTH CENTER FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record F 0684 What corrective action(s) will 07/06/2023 review the facility failed to ensure comprehensive be accomplished for those assessments were performed related to skin residents found to have been conditions for 1 of 3 residents reviewed. (Resident affected by the deficient 65). practice? All nursing staff expected to Findings include: initiate and document assessments related to skin During an observation on 6/12/23 at 12:14 PM the conditions will be educated on following was observed: Resident 65 had a ensuring appropriate interventions dime-sized dry, scabbed area on the right are initiated and documented for palm-side of the wrist. The resident indicated he changes in skin condition. wore a wrist brace frequently. (Attachment 1) How other residents having the Resident 65's record was reviewed on 6/12/23 at potential to be affect by the 2:15 PM. Diagnoses include scoliosis (curvature same deficient practice will be of the spine), contracture of muscle (stiffening of identified and what corrective muscles due to lack of use), and muscle weakness. action(s) will be taken. All residents who experience Resident 65's current quarterly MDS indicated change in skin conditions have the their BIMS (Basic Interview for Mental Status) potential to be affected by the score was 13 (cognitively intact). deficient practice. All nursing staff expected to initiate and document There was no current care plan to address assessments related to skin Resident 65's abrasion to the right wrist. conditions will be educated on ensuring appropriate interventions Current physician orders indicated there were no are initiated and documented for orders to assess the skin under the splint for changes in skin condition. Resident 65's contracture of their right hand. (Attachment 1) What measures will be put into Progress notes dated 6/12/2023 at 5:53 PM place or what systemic indicated Resident 65's right hand was clean, dry, changes will be made to and intact. There were no progress notes to ensure that the deficient indicate the scabbed area on Resident 65's wrist practice does not recur? right wrist had been assessed, when the area had Director of Nursing or her designee

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ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			LETED
		155364	B. W	ING		06/16	/2023
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805 ID PROVIDERS PLAN OF CORRECTION			(X5) COMPLETION
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	
TAG	been discovered, the physician and famic completed. In an interview on indicated the right pink surrounding to the A current policy day Administrator titled Minor Breaks, indicated the residents' medianthe residents' medianthe residents' medianthe residents and designation. The site and designation of the complete statement of the complete statement of the physician and the complete statement of the com	ated 6/16/23 provided by the d Skin Tears - Abrasion and cated to record the following in		TAG	to audit documentation relate skin assessment for 10% of residents monthly times six months to determine complia with assessment and documentation. (Attachment Please specify how the QAP Committee will monitor this plan of correction, how ofter and for how long? If less the six months, how will the fact ensure the plan remains in place? Director of Nursing or her desto audit documentation relate skin assessment for 10% of residents monthly times six months to determine compliate with assessment and documentation. (Attachment Any issues identified during the audit process will be addressed and education will be given to through one-on-one training. Corrective actions taken shall reported to the QAPI Commit during monthly meetings and plan revised, if warranted.	nce 2). n, ian illity signee d to nce 2). he ed o staff Any be tee	DATE
F 0688 SS=D Bldg. 00	§483.25(c) Mobili §483.25(c)(1) The resident who ente range of motion of reduction in range	Decrease in ROM/Mobility ty. e facility must ensure that a ers the facility without limited loes not experience e of motion unless the condition demonstrates					

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unavoidable; and

that a reduction in range of motion is

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155364		00	COMPLETED
	155504				06/16/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				EACON STREET	
BYRON	HEALTH CENTER		FORT	WAYNE, IN 46805	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	§483.25(c)(2) A representation of the services to increase prevent further designation of the services appropriate assistance to may with the maximum unless a reduction demonstrably una Based on observation review the facility exercises and therefore ordered for 1 of 2 modered f	esident with limited range of appropriate treatment and use range of motion and/or to be crease in range of motion. esident with limited mobility rate services, equipment, and intain or improve mobility in practicable independence in in mobility is avoidable. It is not, interview, and record failed to ensure range of motion appy devices were completed as residents reviewed. (Resident foot had foot drop. What we splint in his right hand. The hand was contracted. Resident foot had foot drop. What with Resident 65 on 6/12/23 at the staff do not always do his ney use his splint consistently. The err and oriented x3 throughout assessment dated 5/13/23 at int quarterly MDS (MDS) assessment dated 5/13/23 aving:	F 0688	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? An audit of range of motion exercises and therapy devices be conducted for all residents have orders for range of motion exercise and therapy devices. How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents with range of motion exercises and therapy devices orders had the potential to be affected by this practice. An audio frange of motion exercises and therapy devices will be conducted for range of motions exercises at the tapy devices. All nursing statements who have order the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices. All nursing statements who have ordered the tapy devices.	will who has he e e e e e e e e e e e e e e e e e e
	_	ve Patterns indicated Resident rief Interview of Mental Status)		expected to initiate range of motion exercise and put therap	by

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cognitive decline.

was 13. The score of 13 indicated minimal

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devices in place will be educated

on ensuring range of motion

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of any refusals of care.

Committee during monthly

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	TE SURVEY IPLETED 16/2023				
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			1661 B	STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE			
	risk for reduced join last revision to goal have no contracture right shoulder and experform range of many and the perform range of many and the perform range of many and the performation of the performation should medical record: 1. The performed and performed the of motion exercises exercise was active the person who performed the exercises were accomplaints made by exercises. 8. If the reason why and	at care plan had the focus of at an intervention that mobility dated 9/29/22 with on 5/17/23. A goal was to so to left upper extremity and elbow. An intervention was to otion exercises as prescribed. Inge of Motion Exercises" 10 was provided by the 16/23 at 9:42AM. The policy mentation the following be recorded in the resident's The date exercises were mane and title of the individual exercises. 3. The type of range completed. 4. Whether the or passive. 5. The initials of formed exercises. 6. How long conducted. 7. Any problems or the resident related to resident refused the treatment, the intervention taken. 9. The fifthe person recording the		meetings and the plar warranted.	revised, if				
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such of professional stand comprehensive per	eostomy Care and atory care, including and tracheal suctioning. ensure that a resident who care, including and tracheal suctioning, eare, consistent with lards of practice, the erson-centered care plan, ls and preferences, and							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	lì í	JILDING	00	COMPLETED		
		155364	B. W				06/16/2023	
				CEREE	ADDRESS STEW STATE STR SSS	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
BYRON HEALTH CENTER					EACON STREET			
DIRUNI	ILALITI CENTER			FURIT	WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	483.65 of this sub	•						
		on, interview, and record	F 06	595	What corrective action(s) wi	II	07/06/2023	
	I -	failed to ensure oxygen tubing			be accomplished for those			
		d and labeled when not in use			residents found to have bee	n		
	for 1 of 5 residents	reviewed. (Resident 44)			affected by the deficient			
	E' 1' ' 1 1				practice?			
	Findings include:				All residents on ordered oxyg			
	D 1 .	. (12/22 + 0.57 + 3.5			had the potential to be affected	-		
	_	ion on 6/12/23 at 9:56 AM			this practice. All nursing staff			
	, , ,	a humidifier bottle about 1/3			store and label oxygen will be			
	full of water was observed attached to the oxygen				educated on ensuring oxyger			
	concentrator in Resident 44's room next to her				stored and label appropriately			
	bed. No dates were observed on the bottle or tubing. The tubing was coiled on top of the				when not in use (Attachment	•		
		or with the last 6 inches of the			How other residents having	tne		
					potential to be affect by the	ha		
	tubing, including the nasal cannula, hanging over the front portion of the concentrator. The tubing				same deficient practice will identified and what corrective			
	was not in a labeled	_			action(s) will be taken.	ve		
	was not in a labeled	d oag.			All residents on ordered oxyg	Δn		
	In an interview on t	6/12/23 at 9:56 AM, Licensed			had the potential to be affected			
		PN) 2 indicated oxygen tubing			this practice. All nursing staff	-		
		iles should be changed weekly			store and label oxygen will be			
		anged. She also indicated			educated on ensuring oxyger			
		nould be placed in a dated bag.			stored and label appropriately			
		nlabeled plastic bag from			when not in use (Attachment			
		de table across the room and			What measures will be put i	,		
	placed the tubing ir				place or what systemic			
					changes will be made to			
	In an interview on	6/14/23 at 10:21 AM, the			ensure that the deficient			
	Administrator indic	cated oxygen tubing should be			practice does not recur?			
	labeled, dated, and	changed weekly. She also			Director of Nursing or her des	signee		
	indicated the tubing should be stored in a labeled				to audit the storage and label	-		
	and dated plastic bag when not in use.				oxygen weekly times six mon	-		
					to determine compliance with			
	Resident 44's record was reviewed on 6/14/23 at				proper storage and labeling			
	8:58 AM. Diagnoses included chronic obstructive				(Attachment 6).			
		, anoxic brain damage, not			Please specify how the QAP	PI .		
		d, pneumonia, organism			Committee will monitor this			
	unspecified, and he	eart failure, unspecified.			plan of correction, how ofter	n,		
				and for how long? If less th	an			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL		
		155364	B. WING 06/16/2023			/2023	
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	ROVIDER OR SUPPLIER				EACON STREET		
BYRON I	HEALTH CENTER			FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nt quarterly MDS dated 4/27/23			six months, how will the faci	lity	
		(Basic Interview for Mental			ensure the plan remains in		
	· · · · · · · · · · · · · · · · · · ·	nable to be obtained because able to complete the interview.			place?		
		Resident 44 required total			Director of Nursing or her desi to audit the storage and labeli	-	
		two staff to perform activities			oxygen weekly times six mont	-	
	of daily living.	two starr to perform activities			to determine compliance with	113	
	21 mm1, 11,111g.				proper storage and labeling		
	Resident 44's currer	nt care plan titled "I am at risk			(Attachment 6).		
		ath" indicated Resident 44 had			Any issues identified during th	е	
		less of breath, with a goal date			audit process will be addresse		
	of 7/19/23. Interven	ntions included use of oxygen.			and education will be given to	staff	
					through one-on-one training.	Any	
	-	ted 5/2/23 indicated oxygen			corrective actions taken shall	ре	
		dministered as needed at 2			reported to the QAPI Committe	ee	
	liters per minute for	r aspiration pneumonia.			during monthly meetings and	the	
					plan revised, if warranted.		
	Progress notes indic						
		4/23, 6/5/23, 6/7/23, 6/8/23, and					
	6/10/23.						
	Medication adminis	stration records dated 6/23 and					
		ation records dated 6/23 did					
	not indicate tubing	changes had been performed.					
		led Oxygen Administration					
		provided by the Administrator					
		PM did not address tubing					
		of tubing while not in use.					
		indicated the facility did not					
		ning to tubing changes and					
	storage.						
	3.1-47 (a)(4)(5)(6)						
R 0000							
Bldg. 00							
Diag. 00	This visit was for a	Recertification and State	R 0	000			
		This visit included the	10	000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/16/2023	
		100004	Б. 111			00/10/	2020
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805				
OVA) ID	CUD O () DV	CT A TEN CENTE OF DEPLOYENCE	1		·		975)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	-	mplaint IN00410050. This visit					
		e Residential Licensure					
	Survey.						
	Complaint IN00410050 no deficiencies were cited.						
	Survey dates: June 12, 13, 14, 15, and 16, 2023.						
	Byron Health Center was found to be in						
	compliance with 41	0 IAC 16.2-5 in regard to the					
	Recertification and	State Licensure Survey and					
	the Investigation of	Complaint IN00410050.					
	Quality review completed June 21, 2023						

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