STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BYRON HEALTH CENTER	1661 BEACON STREET FORT WAYNE, IN 46805

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 13, 14, 15, 16 and 19, 2025. Facility number: 000255 Provider number: 155364 AIM number: 100273280 Census Bed Type: SNF/NF: 98 Residential: 47 Total: 145 Census Payor Type: Medicaid: 137 Other: 8 Total: 145 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 20, 2025	F 0000	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** **F 550– Resident Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who administer medication will be educated on ensuring dignity is maintained during medication administration, specifically during meal time. (F550 Attachment 1). **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 who are administered	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Starcher	Executive Director/COO	06/03/2025

Any defiencystatement 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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			medication had the potential to be affected. All nursing staff who administer medication will be educated on ensuring dignity is maintained during medication administration, specifically during meal time. (F550 Attachment 1). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring dignity during medication administration. (F550 Attachment 2). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring dignity during medication administration. (F550 Attachment 2). Any issues identified during the audit process will be addressed immediately. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted.	

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			By what date the systemic changes will be completed: June 19, 2025 **F 583– Privacy of Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who administer medication will be educated on ensuring privacy is maintained. (F583 Attachment 3). **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 who are administered medication had the potential to be affected. All nursing staff who administer medication will be educated on ensuring privacy is maintained. (F583 Attachment 3). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring privacy during medication	

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			administration. (F583 Attachment 4). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring privacy during medication administration. (F583 Attachment 4). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - - - **F 628– Discharge Process**	

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			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All nurses will be educated on ensuring the Bed Hold Policy is communicated to the resident or their representative upon discharge or transfer. (F628 Attachment 5). **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 who have been transferred or discharged had the potential to be affected. All nurses will be educated on ensuring the Bed Hold Policy is communicated to the resident or their representative upon discharge or transfer. (F5628 Attachment 5). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit each transfer or discharge for six months to ensure compliance with communication of the Bed Hold Policy to the resident or their representative. (F628 Attachment 6). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than**	

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			six months, how will the facility ensure the plan remains in place? Director of Nursing or her designee to audit each transfer or discharge for six months to ensure compliance with communication of the Bed Hold Policy to the resident or their representative. (F628 Attachment 6). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - - **F 684 – Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff expected to initiate and document	

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			assessments will be educated on ensuring accurate and timely assessments are documented. (F684 Attachment 7) **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 who experience change in conditions had the potential to be affected. All nursing staff expected to initiate and document assessments will be educated on ensuring accurate and timely assessments are documented. (F684 Attachment 7). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit documentation related to assessments for 10% of residents' monthly times six months to determine compliance with assessment and documentation. (F684 Attachment 8). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit documentation related to assessments for 10% of residents'	

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			monthly times six months to determine compliance with assessment and documentation. (F684 Attachment 8). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - **F 695 – Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who assist with placing and storing will be educated on ensuring oxygen is stored appropriately when not in use and within reach of residents when needed. (F 695 Attachment	

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			9). **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 on ordered oxygen had the potential to be affected by this practice. All nursing staff who assist with placing and storing will be educated on ensuring oxygen is stored appropriately when not in use and within reach of residents when needed. (F 695 Attachment 9). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit the storage and placement of oxygen weekly times six months to determine compliance with proper storage and administration (F 695 Attachment 10). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit the storage and placement of oxygen weekly times six months to determine compliance with proper storage and administration (F 695	

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			Attachment 10). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - - **F 812 – Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff will be educated the proper labeling and dating of food, discarding expired food and ensuring dishes are dried prior to storage (F812 Attachment 11). **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.**	

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			All residents who are served food from the kitchen had the potential to be affected by this practice. All staff will be educated the proper labeling and dating of food, discarding expired food and ensuring dishes are dried prior to storage (F812 Attachment 11). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Dining Services or her designee to review labeling and dating of food, ensure food is properly discarded and dishes are stored appropriately after being washed via observation weekly times six months (F812 Attachment 12). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Dining Services or her designee to review labeling and dating of food, ensure food is properly discarded and dishes are stored appropriately after being washed via observation weekly times six months (F812 Attachment 12). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any	

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			corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review, and interview the facility failed to ensure dignity was maintained for 1 of 1 resident reviewed. (Resident 10) Findings include: During an observation, on 5/15/25 at 7:26AM, Licensed Practical Nurse (LPN) 6 administered medications to Resident 10. The medications were administered in a common area while Resident 10 was sitting eating breakfast at dining table. The medications administered included Trulicity, a subcutaneous injection of a hypoglycemic agent. The Trulicity injection was administered in Resident 10's right upper quadrant of his abdomen after Resident 10 pulled up his shirt revealing his abdomen. In an interview, on 5/15/25 at 9:56AM, LPN 6 indicated she normally would stop giving medications and assist in serving breakfast rather than administering medications during breakfast.	F 0550	**F 550– Resident Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who administer medication will be educated on ensuring dignity is maintained during medication administration, specifically during meal time. (F550 Attachment 1). **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 who are administered medication had the potential to be affected. All nursing staff who administer medication will be educated on ensuring dignity is maintained during medication administration, specifically during	06/19/2025

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	In an interview, on 5/15/25 at 10:10AM, Registered Nurse (RN) 5 indicated nurses were not permitted to give medications in the common area during breakfast due to dignity issues as well as residents were to enjoy their meal without interruptions. Resident 10's record review began on 5/15/25 at 2:06PM. The record indicated diagnoses included type 2 diabetes, chronic gingivitis, and unspecified dementia. Resident 10's care plan did not specify a preference to take medications in the common areas. A current policy, titled "Quality of Life-Dignity" undated, was provided by the administrator on 5/15/25 at 10:23AM. The policy indicated, "2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth ...9.Staff shall maintain an environment in which confidential clinical information was protected, for example: b. signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or the resident's family member. Discreet posting of important of information ....10. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures ..." A current policy, titled "Administered Oral Medications" undated , was provided by the Administrator on 5/15/25 at 10:23AM. The policy indicated, "26. If the resident desires, return the door and curtains to the open position ... 3.1-3(a)		meal time. (F550 Attachment 1). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring dignity during medication administration. (F550 Attachment 2). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring dignity during medication administration. (F550 Attachment 2). Any issues identified during the audit process will be addressed immediately. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	

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F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, interview and record review the facility failed to ensure privacy of electronic and paper medical information for 1 of 20 residents reviewed. (Resident 80) Findings include: During an observation, on 5/14/25 at 10:30 AM, a computer screen on top of a medicine cart was open with Resident 80's name, picture, medication list and other personal health information visible on the screen. A paper worksheet was lying on top of the medicine cart displaying vital signs and other health information for residents on the unit. The medicine cart was observed in a hallway leading to the common areas of the unit where staff and residents were observed passing by. During an observation, on 5/14/25 at 12:31 PM, Registered Nurse (RN) 5 was observed seated next to Resident 80 in the dining room assisting her with lunch. RN 5 rose from her chair, walked to the medicine cart, activated the lock and returned to her seat. The computer on top of the medicine cart was open to Resident 80's medication list and picture. A worksheet with visible vital signs and other resident information was observed sitting on top of the cart. Residents and staff were walking around the area preparing for the lunch meal and were in close enough proximity to view the computer screen and paper. Resident 80's record was reviewed on 5/14/25 at 1:14 PM. Diagnoses included cerebral palsy, abnormal weight loss, dysphagia, and altered mental status.	F 0583	**F 583– Privacy of Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who administer medication will be educated on ensuring privacy is maintained. (F583 Attachment 3). **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 who are administered medication had the potential to be affected. All nursing staff who administer medication will be educated on ensuring privacy is maintained. (F583 Attachment 3). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring privacy during medication administration. (F583 Attachment 4). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than**	06/19/2025

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	A review of Resident 80's current significant change Minimum Data Set Assessment (MDS) dated 5/6/25 indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired). During an interview, on 5/14/25 at 12:40 PM, RN 5 indicated she had prepared and administered Resident 80's medications, but had forgotten to lock the screen when she stepped away from the cart. She indicated the computer screen should have been locked and the worksheet should have been turned over to keep resident information private. During an interview, on 5/16/25 at 12:26 PM, the Director of Nursing (DON) indicated computer screens should be locked when staff were not present and attending to them. The DON indicated any paper records should not have visible resident information in unsecured areas, such as on top of medication carts. A current policy titled Protected Health Information, Management and Protection of, dated 4/07 provided by the Administrator on 5/16/25 at 1:12 PM indicated all personnel with access to resident information should ensure the information is managed and protected to prevent unauthorized disclosure. A current policy titled Confidentiality of Information, dated 7/10/19, indicated all resident records should be safeguarded to protect the confidentiality of the information. The policy indicated access to medical records should be limited to staff and consultants providing care to the resident. 3-1(p)(5)		**six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring privacy during medication administration. (F583 Attachment 4). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BYRON HEALTH CENTER	1661 BEACON STREET FORT WAYNE, IN 46805

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F 0628 SS=D Bldg. 00	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48 Discharge Process Based on record review and interview the facility failed to ensure a bed hold policy was given prior to discharge to 2 of 3 residents reviewed. (Resident 35 and Resident 47) Findings include: 1) Resident 35's record review began on 5/13/25 at 10:33AM. Resident 35's diagnoses included kidney failure, respiratory failure, and pneumonitis due to inhalation of food and vomit. On 10/8/24 Resident 35 was sent to the hospital. There was no documentation to indicate a bed hold had been explained to her or the family in the medical record. The facility was unable to show proof a bed hold was given prior to discharge. 2) Resident 47's record review began on 05/14/25 at 1:34 PM. Resident 47's diagnoses included respiratory failure, dysphagia, and altered mental status. Resident 47 was sent to the hospital on 3/8/25 there was no documentation to indicate a bed hold had been explained to him or his family in the medical record. The facility was unable to provide proof a bed hold was given prior to discharge. In an interview, on 05/16/25 at 12:27 PM, the Director of Nursing (DON) indicated a bed hold policy should have been documented in the progress notes. The DON indicated the resident, a family member, or power of attorney should always be informed of a bed hold policy at discharge prior to leaving the building.	F 0628	**F 628– Discharge Process** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nurses will be educated on ensuring the Bed Hold Policy is communicated to the resident or their representative upon discharge or transfer. (F628 Attachment 5). **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 who have been transferred or discharged had the potential to be affected. All nurses will be educated on ensuring the Bed Hold Policy is communicated to the resident or their representative upon discharge or transfer. (F5628 Attachment 5). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit each transfer or discharge for six months to ensure compliance with communication of the Bed Hold Policy to the resident or their representative. (F628 Attachment 6).	06/19/2025

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	A current policy titled, "Holding Bed Space" was provided by the Administrator on 5/16/25 at 1:12PM. The policy indicated, "Our facility shall inform residents upon admission and prior to transfer for hospitalizations or therapeutic leave of our bed-hold policy ..." No state rule applies.		**Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit each transfer or discharge for six months to ensure compliance with communication of the Bed Hold Policy to the resident or their representative. (F628 Attachment 6). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review the facility failed to ensure assessments were accurately recorded for 2 of 2 residents reviewed. (Resident 1, Resident 35) Findings include: During an observation on 05/16/2025 at 1:38 PM the following was observed: the Director of Nursing approached Resident 1 to check pupils.	F 0684	**F 684 – Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff expected to initiate and document assessments will be educated on ensuring accurate and timely	06/19/2025

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	Upon shining a flashlight in the left eye, the pupil appeared dilated, round and nonreactive to light; the right pupil appeared round, non-dilated, and reacted to light. Resident 1's record was reviewed on 05/14/2025 at 12:53 PM. Diagnoses included 6th abducent nerve palsy (affects the ability to turn the eye outward), 3rd oculomotor nerve palsy (affects the ability for eye to look straight ahead, also effects the pupils ability to constrict to light leaving the pupil dilated), and blepharoconjunctivitis (inflammation of the eyelid and conjunctiva (mucus membrane of eye)). A review of Resident 1's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 5 (severe cognitive impairment). A review of Resident 1's current care plan titled Impaired Vision related to dry eye syndrome, blepharitis (inflamed, itchy eyelids), and ptosis (eyelids droop over eye) indicated the resident had a problem with inflamed, droopy eyelids, with a goal date of 07/23/2025. Interventions included washing eye lids with baby shampoo as ordered, referring to optometry as ordered, and head CT scan as ordered. There was no care plan for unequally sized pupils. A review of progress notes dated 04/30/2025 at 11:43 AM indicated when Resident 1 was seen by the eye doctor, they recommended for her to be sent to the ER for ptosis. The eye doctor believed it could be life threatening. Resident 1 refused to have an MRI performed, but agreed to a CT of the head. Resident 1 had known irregular pupils, had no mental status changes, no headache, no recent head trauma, and no complaints of eye pain.		assessments are documented. (F684 Attachment 7) **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 who experience change in conditions had the potential to be affected. All nursing staff expected to initiate and document assessments will be educated on ensuring accurate and timely assessments are documented. (F684 Attachment 7). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit documentation related to assessments for 10% of residents' monthly times six months to determine compliance with assessment and documentation. (F684 Attachment 8). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit documentation related to assessments for 10% of residents' monthly times six months to determine compliance with	

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	Skilled charting dated 2024 indicated Resident 1's pupils were equal, round, and reactive to light on 07/08, 07/16, 07/22, 07/29, 08/06, 08/12, 08/19, 08/27, 09/02, 09/09, 09/17, 09/30, 10/05, 10/14, 10/21, 10/29, 11/04, 11/05, 11/19, 11/25, 12/02, 12/19, and 12/25. Skilled charting dated 2025 indicated Resident 1's pupils were equal, round, and reactive to light on 01/01, 01/09, 01/22, 02/05, 02/12, 02/20, 03/13, 04/02, 04/03, and 04/24. A review of Resident 1's CT of the Head without contrast, dated 05/08/2025, indicated no acute findings. In an interview, on 05/14/25 at 10:34 AM, the Administrator indicated Resident 1's pupils had been unequal in size since 2022. In an interview, on 05/14/25 at 12:53 PM, the DON indicated the PERRLA (Pupils Equal, Round, and Reactive to Light and Accommodation) documentation needed to be better, and staff would be educated on performing neurological assessments and documentation. In an interview, on 05/16/25 at 09:40 AM, LPN 7 indicated pupils are to be checked when a fall happens and with mental status changes. Resident 1 had not had any mental status changes recently and the nurse was not aware of the resident having unequal pupils. In an interview, on 05/16/25 at 10:00 AM, RN 5 indicated skilled assessments are typically done weekly. If an assessment was missed, then she would make sure to get that done and charted. Resident 35's record was reviewed on 05/13/25 at 10:33 AM. Diagnoses included acute respiratory		assessment and documentation. (F684 Attachment 8). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	

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	failure with hypoxia, pneumonitis (swelling and irritation of lungs) due to inhalation of food and vomit, and dysphagia (difficulty eating). A review of Resident 35's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 3 (severe cognitive impairment). A review of physician's orders, dated 11/13/24, indicated to focus documentation for breath sounds, fever, oxygen saturation below 92% on room air, and increased respiratory rate greater than 24 breaths per minute every shift for 7 days. A review of physician's orders, dated 11/13/24, 11/25/24, and 12/20/24, indicated Resident 35 received chest X-rays for pneumonia and pleural effusion (fluid accumulation between lungs and chest wall). A physician's order, dated 12/11/24, indicated to completeanother follow up chest X-ray for pneumonia with effusion drainage related to recent chest tube removal. Change in condition supportive documentation, dated 11/15/24, indicated no breath sounds were assessed on second shift. On 11/16/24 no breath sounds were assessed for first or second shift. On 11/17/24 no breath sounds were assessed for third shift. In an interview, dated 05/14/25 at 10:53 AM, the DON indicated Resident 35 should have been assessed every shift as ordered. A current policy, dated 02/2014, provided by the DON indicated neurological assessments should include drooping eyelids, facial paralysis, asymmetry, and pupil size.			

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	A current policy dated 02/2014 provided by the DON indicated lung sounds, respirations, cough, consistency and color of sputum, oxygen use and oxygen saturations, and shortness of breath should be assessed during comprehensive assessments. 3.1-37			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure oxygen tubing was appropriately applied and stored when not in use for 1 of 2 residents reviewed. (Resident 28) Findings include: During an observation on 5/13/25 at 12:04 PM oxygen tubing was lying across Resident 28's bed unbagged. The bedside oxygen concentrator was turned on, releasing oxygen while Resident 28 was in the dining room. During an interview on 5/13/25 at 12:05 PM, Licensed Practical Nurse (LPN) 2 indicated bedside oxygen should be turned off when not in use and oxygen tubing should be bagged when not in use. LPN 2 indicated she was unable to find a bag in Resident 28's room to place her oxygen tubing in. During an observation on 05/15/25 10:19 AM, Resident 28 was observed lying on her right side in bed with her chin tucked to her chest, breathing in a labored manner. She was not wearing the oxygen. Resident 28's oxygen tubing was about 2.5 feet away from the resident lying neatly coiled, unbagged on a bedside table. The tubing was attached to an oxygen concentrator that was	F 0695	**F 695 – Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who assist with placing and storing will be educated on ensuring oxygen is stored appropriately when not in use and within reach of residents when needed. (F 695 Attachment 9). **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 on ordered oxygen had the potential to be affected by this practice. All nursing staff who assist with placing and storing will be educated on ensuring oxygen is stored appropriately when not in use and within reach of residents	06/19/2025

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	turned on and releasing oxygen. Resident 28's wheelchair was about 8 feet away from her bed. Resident 28's record was reviewed on 5/15/25 at 10:28 AM. Diagnoses included chronic respiratory failure with hypoxia, hypoxemia, shortness of breath, and need for assistance with personal care. A review of Resident 28's current quarterly Minimum Data Set Assessment (MDS), dated 4/4/25, indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired). The MDS indicated the resident utilized oxygen therapy. A review of Resident 28's current care plan regarding Impaired gas exchange indicated the resident had a problem of shortness of breath, with a goal date of 7/5/25. Interventions included monitoring for signs and symptoms of acute respiratory insufficiency including labored breathing and administering oxygen as directed. A review of physician orders dated 2/17/25 at 4:00 PM indicated oxygen should be administered up to 5 liters per minute for hypoxia or shortness of breath. A review of progress notes did not indicate any refusal of care or oxygen dated 5/15/25. During an interview on 5/15/25 at 10:23 AM, LPN 3 indicated Resident 28 was poorly positioned due to the head of the bed being raised and the resident sliding down causing her chin to tuck toward her chest resulting in labored breathing. She indicated Resident 28 would not have been able to place her oxygen tubing on the table as it was out of her reach and physical ability. She indicated Resident 28 was not able to self-transfer or walk from where her wheelchair was positioned across the room. She indicated Resident 28 should have been positioned better and should have had her nasal cannula placed in her nostrils.		when needed. (F 695 Attachment 9). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit the storage and placement of oxygen weekly times six months to determine compliance with proper storage and administration (F 695 Attachment 10). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit the storage and placement of oxygen weekly times six months to determine compliance with proper storage and administration (F 695 Attachment 10). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	

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	A current policy dated 10/2010, provided by the Administrator on 5/15/25 at 11:35 AM indicated staff should turn on the oxygen at the time of application and place the oxygen device on the resident. A current policy titled Oxygen Storage, dated 8/22/14 did not address storage of oxygen supplies when not in use. 3.1-47(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review the facility failed to ensure kitchen sanitation was maintained, opened food items were labeled and dated, and baking trays were thoroughly air dried. 95 of 96 residents residing in the building were served food prepared in the kitchen. Findings include: During an observation on 5/13/25 at 9:07 AM, A container of ice cream was observed in the walk-in freezer. The dietary manager (DM) opened the container and dip marks where ice cream had been removed were observed. No open date was observed on the container. A large, covered cart was observed in the back of the walk-in cooler with a discard date of 5/11/25. The DM lifted the cart cover revealing individual pieces of cake on plates and bowls of fruit. The fruit and cake were not individually covered and appeared dry.	F 0812	**F 812 – Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff will be educated the proper labeling and dating of food, discarding expired food and ensuring dishes are dried prior to storage (F812 Attachment 11). **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 who are served food from the kitchen had the potential to be affected by this practice. All staff will be educated the proper labeling and dating of food, discarding expired food and ensuring dishes are dried prior to storage (F812 Attachment 11).	06/19/2025

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	A large bin labeled "flour" was observed with a scoop lying in the flour supply. A large bin labeled "sugar" was observed with a scoop lying in the sugar supply. Four chef salads were observed on plates covered with plastic wrap inside the reach-in cooler. No date was observed on any of the salads. An open box of popsicles was observed in the reach in freezer with an expiration date of 3/8/25. A box was observed inside a reach in freezer containing frozen hamburger patties inside a plastic bag. The plastic bag was open leaving the meat open to air. A plastic bag containing breaded chicken strips was observed on a shelf in the freezer. The plastic bag was open with the meat open to air. A plastic bag containing French fries was open with the French fries open to air. No open dates were observed on the hamburger patties, chicken strips or French fries. A shelf next to the fryer was observed with a large amount of yellow oily liquid and brown specks of debris. The reach in freezer across from the fryer had multicolored streaks and splatters on the front of the doors. 3 of 4 baking pans had clear liquid dripping from them when separated in the ready to use baking pan storage stack. In an interview on 5/13/25 at 9:08 AM, the Dietary Manager (DM) indicated the container of ice cream should have been dated when opened. The DM indicated the cart containing the expired fruit and cake should have been disposed of on 5/11/25.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Dining Services or her designee to review labeling and dating of food, ensure food is properly discarded and dishes are stored appropriately after being washed via observation weekly times six months (F812 Attachment 12). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Dining Services or her designee to review labeling and dating of food, ensure food is properly discarded and dishes are stored appropriately after being washed via observation weekly times six months (F812 Attachment 12). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	

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	The DM indicated scoops for flour and sugar should be stored outside the supply. The DM indicated salads in the reach-in cooler should have been dated. The DM indicated the expired box of popsicles should have been discarded upon expiration. The DM indicated packages frozen hamburgers, chicken strips and French Fries should be closed after use to prevent air exposure and dated when opened. The DM indicated the fryer area, including the freezer doors, should have been cleaned after its last use, the previous evening. The DM indicated all baking pans should be air dried on a drying rack and stacked only after they were completely dry. A current policy titled Food Receiving and Storage dated 12/08 provided by the Administrator on 5/13/25 at 1:23 PM indicated Food Services or other staff should always maintain clean food storage areas. The policy indicated all food stored in the refrigerator or freezer should be covered, labeled and dated with a "use by" date. A current policy titled Preventing Foodborne Illness- Food Handling, dated 12/09 provided by the Administrator on 5/13/25 at 1:23 PM indicated all food service equipment should be sanitized according to current guidelines. A current policy titled Dishwashing Machine Use, dated 8/10 indicated after running items through			

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	the dishwasher, the items should be allowed to air dry. 3.1-21(i)(2) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey Survey dates: May 13, 14, 15, 16 and 19, 2025. Facility number: 000255 Residential Census: 47 Byron Health Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed May 20, 2025	R 0000	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** **F 550– Resident Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who administer medication will be educated on ensuring dignity is maintained during medication administration, specifically during meal time.	

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			(F550 Attachment 1). **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 who are administered medication had the potential to be affected. All nursing staff who administer medication will be educated on ensuring dignity is maintained during medication administration, specifically during meal time. (F550 Attachment 1). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring dignity during medication administration. (F550 Attachment 2). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring dignity during medication administration. (F550 Attachment 2).	

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			Any issues identified during the audit process will be addressed immediately. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 **<u>F 583– Privacy of Records</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff who administer medication will be educated on ensuring privacy is maintained. (F583 Attachment 3). **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 who are administered medication had the potential to be affected. All nursing staff who administer medication will be educated on ensuring privacy is maintained. (F583 Attachment 3). **What measures will be put into place or what systemic changes will be made to**	

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			ensure that the deficient practice does not recur? Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring privacy during medication administration. (F583 Attachment 4). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee observe medication administrator one time per week times six months to ensure compliance with ensuring privacy during medication administration. (F583 Attachment 4). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - -	

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			- - - - - - **F 628– Discharge Process** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nurses will be educated on ensuring the Bed Hold Policy is communicated to the resident or their representative upon discharge or transfer. (F628 Attachment 5). **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 who have been transferred or discharged had the potential to be affected. All nurses will be educated on ensuring the Bed Hold Policy is communicated to the resident or their representative upon discharge or transfer. (F5628 Attachment 5). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit each transfer or discharge for six months to ensure compliance with communication of	

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			the Bed Hold Policy to the resident or their representative. (F628 Attachment 6). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit each transfer or discharge for six months to ensure compliance with communication of the Bed Hold Policy to the resident or their representative. (F628 Attachment 6). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - - **F 684 – Quality of Care**	

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			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All nursing staff expected to initiate and document assessments will be educated on ensuring accurate and timely assessments are documented. (F684 Attachment 7) **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 who experience change in conditions had the potential to be affected. All nursing staff expected to initiate and document assessments will be educated on ensuring accurate and timely assessments are documented. (F684 Attachment 7). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit documentation related to assessments for 10% of residents' monthly times six months to determine compliance with assessment and documentation. (F684 Attachment 8). **Please specify how the QAPI Committee will monitor this plan of correction, how often,**	

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			and for how long? If less than six months, how will the facility ensure the plan remains in place? Director of Nursing or her designee to audit documentation related to assessments for 10% of residents' monthly times six months to determine compliance with assessment and documentation. (F684 Attachment 8). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - **F 695 – Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	

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			practice? All nursing staff who assist with placing and storing will be educated on ensuring oxygen is stored appropriately when not in use and within reach of residents when needed. (F 695 Attachment 9). **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 on ordered oxygen had the potential to be affected by this practice. All nursing staff who assist with placing and storing will be educated on ensuring oxygen is stored appropriately when not in use and within reach of residents when needed. (F 695 Attachment 9). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit the storage and placement of oxygen weekly times six months to determine compliance with proper storage and administration (F 695 Attachment 10). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in**	

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			place? Director of Nursing or her designee to audit the storage and placement of oxygen weekly times six months to determine compliance with proper storage and administration (F 695 Attachment 10). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025 - - - - - - - - - - **F 812 – Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff will be educated the proper labeling and dating of food, discarding expired food and	

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			ensuring dishes are dried prior to storage (F812 Attachment 11). **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 who are served food from the kitchen had the potential to be affected by this practice. All staff will be educated the proper labeling and dating of food, discarding expired food and ensuring dishes are dried prior to storage (F812 Attachment 11). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Dining Services or her designee to review labeling and dating of food, ensure food is properly discarded and dishes are stored appropriately after being washed via observation weekly times six months (F812 Attachment 12). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Dining Services or her designee to review labeling and dating of food, ensure food is properly discarded and dishes are stored appropriately after being	

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			washed via observation weekly times six months (F812 Attachment 12). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** June 19, 2025	