STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTR		NSTRUCTION (X3) I		3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
		155364	B. WING 05/19/2025			2025	
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				EACON STREET		
BYRON H	HEALTH CENTER				WAYNE, IN 46805		
(X4) ID	SUMMARY S	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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
			F 00	000	This Plan of Correction is Byro		
		Recertification and State			Health Center's credible allega		
	_	This visit included a State			of compliance. It is the intention		
	Residential Licensu	re Survey.			of Byron Health Center to be in	n	
		10 14 15 16 110 2025			complete compliance with all		
	Survey dates: May	13, 14, 15, 16 and 19, 2025.			Federal and State guidelines.		
	E 117 1 00	0255			Preparation and/or execution of		
	Facility number: 00				this plan of correction does no		
	Provider number: 1:				constitute admission or agreer		
	AIM number: 10027	/3280			by the provider of the truth of t		
	C D- 1 T				facts alleged or conclusions se		
	Census Bed Type: SNF/NF: 98				forth in the state deficiencies.	rne	
	Residential: 47				plan of correction is prepared		
	Total: 145				and/or executed because the	love	
	10141. 143				provisions of federal and state	iaw	
	Census Payor Type:				require it. We are asking for Paper		
	Medicaid: 137				Compliance. Thank you.		
	Other: 8				Compliance. Thank you.		
	Total: 145				- F 550- Resident Rights		
	10441. 1 13				What corrective action(s) will	i	
	These deficiencies r	reflect State Findings cited in			be accomplished for those	•	
	accordance with 410	_			residents found to have been	1	
					affected by the deficient		
	Quality review com	pleted May 20, 2025			practice?		
		•			All nursing staff who administe	er	
					medication will be educated or		
					ensuring dignity is maintained		
					during medication administrati	on,	
					specifically during meal time.		
					(F550 Attachment 1).		
					How other residents having t	he	
					potential to be affect by the		
					same deficient practice will b		
					identified and what corrective	е	
					action(s) will be taken.		
					All residents who are administ	ered	

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

TITLE

(X6) DATE

Sarah Starcher Executive Director/COO 06/03/2025

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 disclodays 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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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COM		(X3) DATE SURVEY COMPLETED 05/19/2025		
	PROVIDER OR SUPPLIE	R	1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	medication had the potential to affected. All nursing staff who administer medication will be educated on ensuring dignity in maintained during medication administration, specifically during meal time. (F550 Attachment What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or her desire observe medication administration one time per week times six months to ensure compliance ensuring dignity during medical administration. (F550 Attachment). Please specify how the QAP Committee will monitor this plan of correction, how often and for how long? If less that six months, how will the facil ensure the plan remains in place? Director of Nursing or her desire observe medication administration in time per week times six months to ensure compliance ensuring dignity during medical administration. (F550 Attachment). Any issues identified during the audit process will be addressed immediately. Any corrective actions taken shall be reported the QAPI Committee during monthly meetings and the plan mediately.	is ring 1). Into dignee actor with action nent lity lignee actor with action nent leed d to d to

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KX8311

Facility ID: 000255

revised, if warranted.

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	FORM APPROVED OMB NO. 0938-039	
(X3) DA	(X3) DATE SURVEY COMPLETED 05/19/2025	
COD		
RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
temic pleted:		
cords on(s) will those ave been ient administer acated on aintained. having the by the ace will be orrective n. administered otential to be taff who a will be privacy is achment 3). be put into nic et to		
in a line in a contact in a con	cated on aintained. having the by the ce will be orrective n. administered atential to be saff who will be privacy is achment 3). The put into bic	

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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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	FICATION NUMBER A. BUILDING O B. WING O COMPLETE 05/19/202		(X3) DATE SURVEY COMPLETED 05/19/2025
	PROVIDER OR SUPPLIE HEALTH CENTER		1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY O	K LOC IDENTIFITING INFORMATION	IAU	administration. (F583 Attachn 4). Please specify how the QAPI Committee will monitor this plan of correction, how often and for how long? If less that six months, how will the faci ensure the plan remains in place? Director of Nursing or her dest observe medication administration etime per week times six months to ensure compliance ensuring privacy during medical administration. (F583 Attachn 4). Any issues identified during the audit process will be addressed. Any corrective actions taken six be reported to the QAPI Committee during monthly meetings and the plan revised warranted. By what date the systemic changes will be completed: June 19, 2025	nent I, an lity ignee ator with cation nent ae ed. shall

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F 628- Discharge Process

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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 00	(X3) DATE SURVEY COMPLETED 05/19/2025	
	ROVIDER OR SUPPLIER		1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805	
BIIKOIVI	ILAETH OLIVIER		110111		1
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				What corrective action(s) wi	ll
				be accomplished for those	
				residents found to have bee	n
				affected by the deficient	
				practice? All nurses will be educated or	
				ensuring the Bed Hold Policy	
				communicated to the resident	
				their representative upon	. 51
				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	/e
				action(s) will be taken.	
				All residents who have been	
				transferred or discharged had	
				potential to be affected. All nu	
				will be educated on ensuring	
				Bed Hold Policy is communic	ated
				to the resident or their	
				representative upon discharg	
				transfer. (F5628 Attachment & What measures will be put in	'
				place or what systemic	
				changes will be made to	
				ensure that the deficient	
				practice does not recur?	
				Director of Nursing or her des	ignee
				to audit each transfer or disch	-
				for six months to ensure	
				compliance with communicati	on of
				the Bed Hold Policy to the	
				resident or their representativ	e.
				(F628 Attachment 6).	.
				Please specify how the QAP	l
				Committee will monitor this	
				plan of correction, how often	
				and for how long? If less th	an

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
		155364	B. WING 05/19/2025				2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			EACON STREET		
BVD∩N I	LEVI TH CENTED				WAYNE, IN 46805		
DIKONI	HEALTH CENTER			FORT	WATNE, IN 40803		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					six months, how will the faci	lity	
					ensure the plan remains in		
					place?		
					Director of Nursing or her desi	ignee	
					to audit each transfer or disch	arge	
					for six months to ensure		
					compliance with communication	on of	
					the Bed Hold Policy to the		
					resident or their representative	€.	
					(F628 Attachment 6).		
					Any issues identified during th		
					audit process will be addresse		
					Any corrective actions taken s	hall	
					be reported to the QAPI		
					Committee during monthly		
					meetings and the plan revised	l, if	
					warranted.		
					By what date the systemic		
					changes will be completed:		
					June 19, 2025		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					- F 694 Ovelity of Com		
					F 684 – Quality of Care		
					What corrective action(s) will	ı	
					be accomplished for those		
					residents found to have been	1	
					affected by the deficient		
					practice?		
					All nursing staff expected to		
			1		initiate and document		

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/19/2025
	ROVIDER OR SUPPLIE		1661 B	ADDRESS, CITY, STATE, ZIP COD SEACON STREET WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				assessments will be educate ensuring accurate and timely assessments are documented (F684 Attachment 7) How other residents having potential to be affect by the same deficient practice will identified and what correcting action(s) will be taken. All residents who experience change in conditions had the potential to be affected. All nestaff 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 in place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or her deto audit documentation related assessments for 10% of residemental (F684 Attachment 8). Please specify how the QAI Committee will monitor this plan of correction, how often and for how long? If less the six months, how will the face ensure the plan remains in place? Director of Nursing or her deto audit documentation related assessments for 10% of resident designation of the plan remains in place? Director of Nursing or her deto audit documentation related assessments for 10% of residence?	the be ve ursing pe ate ent into signee ed to dents' tion. Pl in, nan cility signee ed to

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364 INVING INVINCE INVING INVINCE INVING INVINCE INV	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (EACH 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	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE TAG SUMMARY STATEMENT OF DEFICIENCY TAG Monthly times six months to determine compliance with assessesment 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	155364		B. WING 05/1			05/19/	2025	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (CROSS REFERENCE TO THE APPROPRIATE DEFENSATE DEFENSAT			2	•	1661 B	EACON STREET		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (CROSS REFERENCE TO THE APPROPRIATE DEFENSATE DEFENSAT	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	I		(X5)
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						PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
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		•				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
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	TAG	•				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 through one-on-one training. corrective actions taken shall be reported to the QAPI Committed during monthly meetings and splan revised, if warranted. By what date the systemic changes will be completed: June 19, 2025	e ed staff Any be ee the	DATE

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/19/2025	
	ROVIDER OR SUPPLIEI	₹	1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				9). How other residents having potential to be affect by the same deficient practice will identified and what correctivaction(s) will be taken. All residents on ordered oxyghad the potential to be affected this practice. All nursing staff assist with placing and storing be educated on ensuring oxygis stored appropriately when use and within reach of reside when needed. (F 695 Attachmage). What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or her desto audit the storage and placement of oxygen weekly six months to determine compliance with proper storage and administration (F 695 Attachment 10). Please specify how the QAP Committee will monitor this plan of correction, how often and for how long? If less the six months, how will the face ensure the plan remains in place? Director of Nursing or her desto audit the storage and placement of oxygen weekly six months to determine compliance with proper storage and placement of oxygen weekly six months to determine compliance with proper storage and administration (F 695	the be ye en ed by who g will gen not in ents nent nto dignee times ge l n, an ility dignee times

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/19/2025
	ROVIDER OR SUPPLIER	3	1661 B	ADDRESS, CITY, STATE, ZIP CO EACON STREET WAYNE, IN 46805	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CTION (X5) ULD BE PROPRIATE COMPLETION DATE
				Attachment 10). Any issues identified duraudit process will be add and education will be give through one-on-one train corrective actions taken reported to the QAPI Coduring monthly meetings plan revised, if warrante By what date the system changes will be compled June 19, 2025	dressed yen to staff ning. Any shall be mmittee and the d. mic eted: the ebeen at the ng of food, and d prior to nt 11). eving the y the e will be

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/19/2025
	ROVIDER OR SUPPLIE		1661 B	ADDRESS, CITY, STATE, ZIP COD SEACON STREET WAYNE, IN 46805	•
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) LD BE COMPLETION COMPLETION DATE	
				All residents who are senfrom the kitchen had the to be affected by this practical staff will be educated the labeling and dating of food discarding expired food a ensuring dishes are dried storage (F812 Attachment What measures will be pure place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Dining Service designee to review labeling dating of food, ensure food properly discarded and distored appropriately after washed via observation with times six months (F812 Attachment 12). Please specify how the Committee will monitor plan of correction, how and for how long? If less six months, how will the ensure the plan remains place? Director of Dining Service designee to review labeling dating of food, ensure food properly discarded and distored appropriately after washed via observation with the six months (F812 Attachment 12). Any issues identified duri audit process will be additing and education will be given through one-on-one training the six month of the plan remains place?	potential ctice. All proper d, and prior to at 11). put into to at

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364			(X2) MULTIPLE C A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 05/19/2025	
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER		1661 E	ADDRESS, CITY, STATE, ZIP COD BEACON STREET WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
				corrective actions taken shall be reported to the QAPI Committe during monthly meetings and the plan revised, if warranted. By what date the systemic changes will be completed: June 19, 2025	e	
F 0550 SS=D Bldg. 00	interview the facility maintained for 1 of 10) Findings include: During an observat Licensed Practical medications to Result administered in a cwas sitting eating by the medications account and the medications account and the Trulicity inject Resident 10's right		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 administed medication had the potential to affected. All nursing staff who	n, ne e	

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In an interview, on 5/15/25 at 9:56AM, LPN 6

medications and assist in serving breakfast rather

than administering medications during breakfast.

indicated she normally would stop giving

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administer medication will be

educated on ensuring dignity is

administration, specifically during

maintained during medication

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155364	B. WING		05/19/2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID ID	1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	` `	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	In an interview, on Nurse (RN) 5 indicated, "26. If the diagram of the diagram of specific type and the diagram of the resident of the r	5/15/25 at 10:10AM, Registered ated nurses were not permitted in the common area during nity issues as well as a gioy their meal without		meal time. (F550 Attachment What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or her des observe medication administration administration one time per week times six months to ensure compliance ensuring dignity during medica administration. (F550 Attachmed). Please specify how the QAP Committee will monitor this plan of correction, how ofter and for how long? If less that six months, how will the faci ensure the plan remains in place? Director of Nursing or her des observe medication administration administration administration one time per week times six months to ensure compliance ensuring dignity during medica administration. (F550 Attachmed). Any issues identified during the audit process will be addressed immediately. Any corrective actions taken shall be reported the QAPI Committee during monthly meetings and the plan revised, if warranted. By what date the systemic changes will be completed: June 19, 2025	ignee ator with ation nent ignee ator with ation nent ignee ator with ation ed ator we ded ded ded to

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155364	B. WI	NG		05/19/2025	
	PROVIDER OR SUPPLIER		•	1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DI ANI OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
F 0583	483.10(h)(1)-(3)(i)	(ii)					
SS=D	Personal Privacy/0	Confidentiality of Records					
Bldg. 00							
		on, interview and record	F 05	583	F 583- Privacy of Records	06/19/2025	
	_	ailed to ensure privacy of			What corrective action(s) wil	I	
		r medical information for 1 of			be accomplished for those		
	20 residents reviewe	ed. (Resident 80)			residents found to have been	n	
					affected by the deficient		
	Findings include:				practice?		
					All nursing staff who administe		
	•	on, on 5/14/25 at 10:30 AM, a			medication will be educated o		
	•	top of a medicine cart was			ensuring privacy is maintained	d.	
	-	80's name, picture, medication			(F583 Attachment 3).		
	-	nal health information visible			How other residents having	the	
		per worksheet was lying on			potential to be affect by the		
	-	cart displaying vital signs and			same deficient practice will be		
		ation for residents on the unit.			identified and what correctiv	e	
		vas observed in a hallway			action(s) will be taken.		
		non areas of the unit where			All residents who are administ		
	stair and residents w	vere observed passing by.			medication had the potential to	o be	
	D	5/14/25 -4 12:21 DM			affected. All nursing staff who		
	-	on, on 5/14/25 at 12:31 PM, RN) 5 was observed seated			administer medication will be	:-	
	-	in the dining room assisting			educated on ensuring privacy		
		5 rose from her chair, walked			maintained. (F583 Attachmen	· ·	
		, activated the lock and			What measures will be put in place or what systemic		
		The computer on top of the			changes will be made to		
		pen to Resident 80's			ensure that the deficient		
		picture. A worksheet with			practice does not recur?		
		nd other resident information			Director of Nursing or her desi	ignee	
	_	g on top of the cart. Residents			observe medication administra	_	
	_	ing around the area preparing			one time per week times six		
		and were in close enough			months to ensure compliance	with	
		ne computer screen and paper.			ensuring privacy during medic		
	, , , , , , , , , , , , , , , , , , ,	1 FF			administration. (F583 Attachn		
	Resident 80's record	l was reviewed on 5/14/25 at			4).	· [
		s included cerebral palsy,			Please specify how the QAP	ı	
		ss, dysphagia, and altered			Committee will monitor this		
	mental status.				plan of correction, how ofter	ո,	
					and for how long? If less tha		

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 05/19/2025 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A review of Resident 80's current significant six months, how will the facility change Minimum Data Set Assessment (MDS) ensure the plan remains in dated 5/6/25 indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively Director of Nursing or her designee impaired). observe medication administrator one time per week times six During an interview, on 5/14/25 at 12:40 PM, RN 5 months to ensure compliance with indicated she had prepared and administered ensuring privacy during medication Resident 80's medications, but had forgotten to administration. (F583 Attachment lock the screen when she stepped away from the cart. She indicated the computer screen should Any issues identified during the have been locked and the worksheet should have audit process will be addressed. been turned over to keep resident information Any corrective actions taken shall private. be reported to the QAPI Committee during monthly During an interview, on 5/16/25 at 12:26 PM, the meetings and the plan revised, if Director of Nursing (DON) indicated computer warranted. screens should be locked when staff were not present and attending to them. The DON indicated any paper records should not have By what date the systemic visible resident information in unsecured areas, changes will be completed: such as on top of medication carts. June 19, 2025 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)

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155364	B. W	NG		05/19/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				EACON STREET		
BYRON H	HEALTH CENTER		_		VAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0628		-(6)(8)(d)(1)(2); 48					
SS=D	Discharge Process	s					
Bldg. 00							
		riew and interview the facility	F 06	528	F 628- Discharge Process		06/19/2025
		ed hold policy was given prior			What corrective action(s) wil	I	
	_	3 residents reviewed.			be accomplished for those		
	(Resident 35 and Re	esident 47)			residents found to have beer	1	
	TO 11 1 1 1				affected by the deficient		
	Findings include:				practice?		
	1) D : 1 + 25!	1 . 1 . 5/13/25 .			All nurses will be educated on		
	· ·	ord review began on 5/13/25 at			ensuring the Bed Hold Policy i		
		t 35's diagnoses included			communicated to the resident	or	
	due to inhalation of	iratory failure, and pneumonitis			their representative upon		
	due to innaration of	food and voinit.			discharge or transfer. (F628		
	On 10/9/24 Pagidan	at 35 was sent to the hospital.			Attachment 5).	ih a	
		nentation to indicate a bed			How other residents having to	ine	
		ined to her or the family in the			potential to be affect by the same deficient practice will be		
	_	e facility was unable to show			identified and what correctiv		
		s given prior to discharge.			action(s) will be taken.	e	
	proor a oca nota wa	is given prior to discharge.			All residents who have been		
	2) Resident 47's rec	ord review began on 05/14/25			transferred or discharged had	the	
		nt 47's diagnoses included			potential to be affected. All nu		
		dysphagia, and altered mental			will be educated on ensuring t		
	status.				Bed Hold Policy is communication		
					to the resident or their		
	Resident 47 was ser	nt to the hospital on 3/8/25			representative upon discharge	or	
		nentation to indicate a bed			transfer. (F5628 Attachment 5		
	hold had been expla	ined to him or his family in the			What measures will be put in		
	medical record. The	facility was unable to provide			place or what systemic		
	proof a bed hold wa	s given prior to discharge.			changes will be made to		
					ensure that the deficient		
	In an interview, on	05/16/25 at 12:27 PM, the			practice does not recur?		
	_	(DON) indicated a bed hold			Director of Nursing or her desi	gnee	
		been documented in the			to audit each transfer or disch	arge	
		DON indicated the resident, a			for six months to ensure		
		power of attorney should			compliance with communication	on of	
	-	of a bed hold policy at			the Bed Hold Policy to the		
	discharge prior to le	eaving the building.			resident or their representative	Э.	
					(F628 Attachment 6).		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155364	A. BUILDII B. WING	NG <u>00</u>	COMPLETED 05/19/2025
		100004			00/10/2020
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 61 BEACON STREET	
BYRON I	HEALTH CENTER			ORT WAYNE, IN 46805	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROP	
TAG		ed, "Holding Bed Space" was	TA	9	DATE
		ministrator on 5/16/25 at		Please specify how the QA Committee will monitor thi	
	1 *	indicated, "Our facility shall		plan of correction, how oft	
		on admission and prior to		and for how long? If less	
	_	izations or therapeutic leave of		six months, how will the fa	
	our bed-hold policy	"		ensure the plan remains in	ı
				place?	
				Director of Nursing or her do	-
	No state rule applie	S.		to audit each transfer or dis	charge
				for six months to ensure compliance with communication	ation of
				the Bed Hold Policy to the	ILLOIT OI
				resident or their representat	ive.
				(F628 Attachment 6).	
				Any issues identified during	the
				audit process will be addres	sed.
				Any corrective actions taker	ı shall
				be reported to the QAPI	
				Committee during monthly	
				meetings and the plan revis	ed, if
				warranted.	
				Divisibat data the assatemic	
				By what date the systemic changes will be completed	
				June 19, 2025	•
F 0684	483.25				
SS=D	Quality of Care				
Bldg. 00	Based on observation	on, interview and record	F 0684	F 684 – Quality of Care	06/19/2025
		ailed to ensure assessments	1 0004	What corrective action(s)	
	I -	orded for 2 of 2 residents		be accomplished for those	
	reviewed. (Resident			residents found to have be	
				affected by the deficient	
	Findings include:			practice?	
				All nursing staff expected to	
	_	on on 05/16/2025 at 1:38 PM		initiate and document	
	_	bserved: the Director of		assessments will be educat	
	I Nursing approached	Resident 1 to check pupils.		ensuring accurate and timel	V I

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

		JILDING 00 COMPLETED ING 05/19/2025			ETED		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD EACON STREET		
BYRON I	HEALTH CENTER				WAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION alight in the left eye, the pupil		TAG	assessments are documented		DATE
					(F684 Attachment 7)	•	
	appeared dilated, round and nonreactive to light; the right pupil appeared round, non-dilated, and				How other residents having t	he	
	reacted to light.	area reama, non unacea, and			potential to be affect by the		
					same deficient practice will be	oe	
	Resident 1's record	was reviewed on 05/14/2025 at			identified and what correctiv		
	12:53 PM. Diagnose	es included 6th abducent nerve			action(s) will be taken.		
	palsy (affects the ab	ility to turn the eye outward),			All residents who experience		
	3rd oculomotor nerv	ve palsy (affects the ability for			change in conditions had the		
	eye to look straight	ahead, also effects the pupils			potential to be affected. All nu	rsing	
	-	o light leaving the pupil			staff expected to initiate and		
	dilated), and blepharoconjunctivitis (inflammation				document assessments will be		
	of the eyelid and conjunctiva (mucus membrane of			educated on ensuring accurate			
	eye)).			and timely assessments are			
				documented. (F684 Attachment			
		nt 1's current quarterly MDS			7).		
		S (Basic Interview for Mental			What measures will be put in	ito	
	Status) score was 5	(severe cognitive impairment).			place or what systemic		
	A marriagy of Docidar	at the exament some when titled			changes will be made to		
		nt 1's current care plan titled ated to dry eye syndrome,			ensure that the deficient		
	_	d, itchy eyelids), and ptosis			practice does not recur? Director of Nursing or her desi	anoo	
		eye) indicated the resident			to audit documentation related	-	
		inflamed, droopy eyelids, with			assessments for 10% of reside		
	_	/2025. Interventions included			monthly times six months to	51110	
	_	th baby shampoo as ordered,		determine compliance with			
		ry as ordered, and head CT			assessment and documentation	on.	
		ere was no care plan for			(F684 Attachment 8).		
	unequally sized pup	ils.			Please specify how the QAPI		
					Committee will monitor this		
		s notes dated 04/30/2025 at			plan of correction, how often	١,	
		when Resident 1 was seen by			and for how long? If less that		
		recommended for her to be			six months, how will the faci	lity	
	•	tosis. The eye doctor believed			ensure the plan remains in		
		tening. Resident 1 refused to			place?		
	_	med, but agreed to a CT of the			Director of Nursing or her desi		
		d known irregular pupils, had			to audit documentation related		
		anges, no headache, no recent complaints of eye pain.			assessments for 10% of reside	ents	
	neau nauma, and no	complaints of eye pain.			monthly times six months to determine compliance with		
					determine compilance with		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		155364	B. W	ING		05/19/	/2025
				CTREET	ADDRESS CITY STATE TIP COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DVDONI	LIEAL TH OFNITED				EACON STREET		
BYRON	HEALTH CENTER			FORT	WAYNE, 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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Skilled charting dat	ed 2024 indicated Resident 1's			assessment and documentation	on.	
	pupils were equal, r	ound, and reactive to light on			(F684 Attachment 8).		
	07/08, 07/16, 07/22, 07/29, 08/06, 08/12, 08/19,				Any issues identified during th	ie	
	08/27, 09/02, 09/09	, 09/17, 09/30, 10/05, 10/14,			audit process will be addresse		
	10/21, 10/29, 11/04	, 11/05, 11/19, 11/25, 12/02,			and education will be given to		
	12/19, and 12/25.				through one-on-one training.		
	Skilled charting dat	ed 2025 indicated Resident 1's			corrective actions taken shall		
	_	round, and reactive to light on			reported to the QAPI Committ	ee	
		, 02/05, 02/12, 02/20, 03/13,			during monthly meetings and		
	04/02, 04/03, and 0-				plan revised, if warranted.		
	A review of Reside	nt 1's CT of the Head without			By what date the systemic		
	contrast, dated 05/08/2025, indicated no acute				changes will be completed:		
	findings.				June 19, 2025		
	In an interview, on	05/14/25 at 10:34 AM, the					
	Administrator indic	ated Resident 1's pupils had					
	been unequal in size	e since 2022.					
		05/14/25 at 12:53 PM, the DON					
		LA (Pupils Equal, Round, and					
		nd Accommodation)					
		led to be better, and staff					
		on performing neurological					
	assessments and do	cumentation.					
		05/16/25 at 09:40 AM, LPN 7					
		to be checked when a fall					
		nental status changes.					
		had any mental status changes					
	1	rse was not aware of the					
	resident having une	qual pupils.					
	l <u> </u>						
		05/16/25 at 10:00 AM, RN 5					
		sessments are typically done					
	1	sment was missed, then she					
	would make sure to	get that done and charted.					
		d was reviewed on 05/13/25 at					
	10:33 AM. Diagnos	ses included acute respiratory					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155364	B. W	/ING		05/19/	/2025
				CTD FFT A	DDDEGG GITY GTATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DVD ON I	LEAL THE OFFITED				EACON STREET		
BYRON	HEALTH CENTER			FORTV	VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	failure with hypoxi	ia, pneumonitis (swelling and					
	irritation of lungs)	due to inhalation of food and					
	vomit, and dysphagia (difficulty eating).						
	A review of Reside	ent 35's current quarterly MDS					
	indicated their BIM	IS (Basic Interview for Mental					
		s (severe cognitive impairment).					
	,						
	A review of physic	cian's orders, dated 11/13/24,					
		documentation for breath					
		gen saturation below 92% on					
		ased respiratory rate greater					
	· ·	minute every shift for 7 days.					
	1						
	A review of physic	eian's orders, dated 11/13/24,					
		0/24, indicated Resident 35					
		ays for pneumonia and pleural					
		amulation between lungs and					
	chest wall).	annulation between rungs und					
	A physician's order	r, dated 12/11/24, indicated to					
		ollow up chest X-ray for					
		fusion drainage related to					
	recent chest tube re	C					
	100000000000000000000000000000000000000						
	Change in conditio	on supportive documentation,					
	1	licated no breath sounds were					
		I shift. On 11/16/24 no breath					
		sed for first or second shift.					
		eath sounds were assessed for					
	third shift.	sam sounds were assessed for					
	ama siiiti						
	In an interview da	ted 05/14/25 at 10:53 AM, the					
		sident 35 should have been					
	assessed every shif						
	assessed every silli	e do Ordered.					
	A current policy d	ated 02/2014, provided by the					
		arcd 02/2014, provided by the arclogical assessments should					
		yelids, facial paralysis,					
	asymmetry, and pu						
	asymmetry, and pu	ipii size.					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/19/2025	
	PROVIDER OR SUPPLIER	2	16	REET ADDRESS, CITY, STATE, ZI 661 BEACON STREET ORT WAYNE, IN 46805	P COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
mo	A current policy da DON indicated lung consistency and col oxygen saturations,	ted 02/2014 provided by the g sounds, respirations, cough, or of sputum, oxygen use and and shortness of breath during comprehensive				Bills	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Trach Suctioning	eostomy Care and					
	review, the facility was appropriately a use for 1 of 2 reside Findings include: During an observat oxygen tubing was unbagged. The bediturned on, releasing in the dining room. During an interview Licensed Practical bedside oxygen shouse and oxygen tubing in the dining room. During an interview Licensed Practical bedside oxygen shouse and oxygen tubing in Use. LPN 2 if find a bag in Reside oxygen tubing in. During an observat Resident 28 was obin bed with her chir in a labored manner oxygen. Resident 22.5 feet away from unbagged on a beds	on, interview and record failed to ensure oxygen tubing applied and stored when not in ents reviewed. (Resident 28) ion on 5/13/25 at 12:04 PM lying across Resident 28's bed side oxygen concentrator was a oxygen while Resident 28 was by on 5/13/25 at 12:05 PM, Nurse (LPN) 2 indicated ould be turned off when not in ing should be bagged when undicated she was unable to ent 28's room to place her ion on 05/15/25 10:19 AM, asserved lying on her right side in tucked to her chest, breathing in the 28's oxygen tubing was about the resident lying neatly coiled, side table. The tubing was gen concentrator that was	F 0695	Respiratory/Trache and Suctioning What corrective act be accomplished for residents found to affected by the defi practice? All nursing staff who placing and storing we ducated on ensuring stored appropriately use and within reach when needed. (F 69 9). How other resident potential to be affected and what action(s) will be take All residents on order had the potential to this practice. All nurse assist with placing a be educated on ensuring stored appropriated use and within reach and within reach appropriated use and within reach and stored appropriated use and within reach and successive accessive actions.	tion(s) will or those have been icient assist with will be ng oxygen is when not in h of residents shaving the ct by the ctice will be a corrective ken. ered oxygen be affected by sing staff who and storing will uring oxygen ely when not in	06/19/2025	

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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 05/19/2025 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 turned on and releasing oxygen. Resident 28's when needed. (F 695 Attachment wheelchair was about 8 feet away from her bed. What measures will be put into Resident 28's record was reviewed on 5/15/25 at place or what systemic 10:28 AM. Diagnoses included chronic respiratory changes will be made to failure with hypoxia, hypoxemia, shortness of ensure that the deficient breath, and need for assistance with personal practice does not recur? Director of Nursing or her designee A review of Resident 28's current quarterly to audit the storage and Minimum Data Set Assessment (MDS), dated placement of oxygen weekly times 4/4/25, indicated their Basic Interview for Mental six months to determine Status (BIMS) score was 3 (cognitively impaired). compliance with proper storage The MDS indicated the resident utilized oxygen and administration (F 695 therapy. Attachment 10). A review of Resident 28's current care plan Please specify how the QAPI regarding Impaired gas exchange indicated the Committee will monitor this resident had a problem of shortness of breath, plan of correction, how often, with a goal date of 7/5/25. Interventions included and for how long? If less than monitoring for signs and symptoms of acute six months, how will the facility respiratory insufficiency including labored ensure the plan remains in breathing and administering oxygen as directed. place? A review of physician orders dated 2/17/25 at 4:00 Director of Nursing or her designee PM indicated oxygen should be administered up to audit the storage and to 5 liters per minute for hypoxia or shortness of placement of oxygen weekly times six months to determine A review of progress notes did not indicate any compliance with proper storage refusal of care or oxygen dated 5/15/25. and administration (F 695 During an interview on 5/15/25 at 10:23 AM, LPN Attachment 10). 3 indicated Resident 28 was poorly positioned due Any issues identified during the to the head of the bed being raised and the audit process will be addressed resident sliding down causing her chin to tuck and education will be given to staff toward her chest resulting in labored breathing. through one-on-one training. Any She indicated Resident 28 would not have been corrective actions taken shall be able to place her oxygen tubing on the table as it reported to the QAPI Committee was out of her reach and physical ability. She during monthly meetings and the indicated Resident 28 was not able to self-transfer plan revised, if warranted. or walk from where her wheelchair was positioned across the room. She indicated Resident 28 By what date the systemic should have been positioned better and should changes will be completed:

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have had her nasal cannula placed in her nostrils.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILE		00	COMPL	
		155364	B. WING			05/19/	2025
	PROVIDER OR SUPPLIER HEALTH CENTER		1	661 BE	DDRESS, CITY, STATE, ZIP COD EACON STREET VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
F 0812 SS=E Bldg. 00	Administrator on 5/staff should turn on application and place resident. A current policy titl 8/22/14 did not adds supplies when not in 3.1-47(a)(6) 483.60(i)(1)(2) Food Procurement, Store Based on observation review the facility of sanitation was main were labeled and dathoroughly air dried the building were sekitchen. Findings include: During an observation container of ice creatives. The dietary container and dip more removed were observed on the container of the contain	e/Prepare/Serve-Sanitary on, interview and record failed to ensure kitchen stained, opened food items sted, and baking trays were 1. 95 of 96 residents residing in terved food prepared in the ston on 5/13/25 at 9:07 AM, A tam was observed in the walk-in ty manager (DM) opened the starks where ice cream had been treed. No open date was	F 0812		F 812 – Food Procurement, Store/Prepare/Serve-Sanitary What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? All staff will be educated the proper labeling and dating of fi- discarding expired food and ensuring dishes are dried prior storage (F812 Attachment 11) How other residents having to potential to be affect by the same deficient practice will be identified and what correctiv action(s) will be taken. All residents who are served for from the kitchen had the potent to be affected by this practice. staff will be educated the prop labeling and dating of food, discarding expired food and ensuring dishes are dried prior storage (F812 Attachment 11)	ood, r to . the e ood ntial All er	06/19/2025

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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 05/19/2025 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 A large bin labeled "flour" was observed with a What measures will be put into scoop lying in the flour supply. A large bin place or what systemic labeled "sugar" was observed with a scoop lying changes will be made to in the sugar supply. ensure that the deficient practice does not recur? Four chef salads were observed on plates covered Director of Dining Services or her with plastic wrap inside the reach-in cooler. No designee to review labeling and date was observed on any of the salads. dating of food, ensure food is properly discarded and dishes are An open box of popsicles was observed in the stored appropriately after being reach in freezer with an expiration date of 3/8/25. washed via observation weekly times six months (F812 A box was observed inside a reach in freezer Attachment 12). containing frozen hamburger patties inside a Please specify how the QAPI plastic bag. The plastic bag was open leaving the Committee will monitor this meat open to air. A plastic bag containing plan of correction, how often. breaded chicken strips was observed on a shelf in and for how long? If less than the freezer. The plastic bag was open with the six months, how will the facility meat open to air. A plastic bag containing French ensure the plan remains in fries was open with the French fries open to air. place? No open dates were observed on the hamburger Director of Dining Services or her patties, chicken strips or French fries. designee to review labeling and dating of food, ensure food is A shelf next to the fryer was observed with a large properly discarded and dishes are amount of yellow oily liquid and brown specks of stored appropriately after being debris. The reach in freezer across from the fryer washed via observation weekly had multicolored streaks and splatters on the front times six months (F812 of the doors. Attachment 12). Any issues identified during the 3 of 4 baking pans had clear liquid dripping from audit process will be addressed them when separated in the ready to use baking and education will be given to staff pan storage stack. through one-on-one training. Any corrective actions taken shall be In an interview on 5/13/25 at 9:08 AM, the Dietary reported to the QAPI Committee Manager (DM) indicated the container of ice during monthly meetings and the cream should have been dated when opened. plan revised, if warranted. The DM indicated the cart containing the expired By what date the systemic fruit and cake should have been disposed of on changes will be completed:

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NAME OF PROVIDIR OR SUPPLIER BYRON HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP COD 1686 BEACON STREET FORT WAYNE, IN 46805 PREFIX TAG 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 discarded upon expiration. The DM indicated packages frozen hamburgers, chicken strips and French Fries should be elosed 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 backing pans should be air dried on a dying 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 \$1/325 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 \$7.1325 at 1:23 PM indicated all food service equipment should be sanitized according to current guidelines.		IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER OX4) ID PREFIX TAG TAG The DM indicated scoops for flour and sugar should be stored outside the supply. The DM indicated sulads in the reach-in cooler should have been discarded upon expiration. The DM indicated the expired box of popsicles should have been discarded upon expiration. The DM indicated the fyer 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 rank and stacked only after they were completely dry. A current policy titled Food Receiving and Storage dated 1208 provided by the Administrator on \$713.25 at 1;23 PM indicated Food Services or other staff should always maintain clean flood 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 Foodborne Illness-Food Handling, dated 1209 provided by the Administrator on \$713.25 at 1;23 PM indicated all food service equipment should be samized according to current guidelines.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155364	A. BUILDING B. WING	00	COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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 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 all baking pans should be air diried 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 \$1/325 at 123 PM indicated Food Services or other staff's 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 \$1/3125 at 123 PM indicated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all food service equipment should be sanitized all coordinated all sh			100007	_	ADDRESS CITY OF THE TIP COS	33/13/2023
DYRON HEALTH CENTER	NAME OF P	PROVIDER OR SUPPLIER				
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION 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 distarded 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 diried 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.	BYRON I	HEALTH CENTER				<u>.</u>
TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 12/3 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.	1 1					
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.		·			CROSS-REFERENCED TO THE APPROPRIA	AIE
		The DM indicated should have been day should have been day the DM indicated to should have been day the DM indicated to should have been did to the DM indicated to chicken strips and Fafter use to prevent opened. The DM indicated to freezer doors, should last use, the previous the DM indicated and dried on a drying rawere completely dry were completely dry to A current policy titl Storage dated 12/08 Administrator on 5/Food Services or ot maintain clean food indicated all food streezer should be contained to the Administrator on all food service equivalent.	scoops for flour and sugar traide the supply. Salads in the reach-in cooler ated. She expired box of popsicles iscarded upon expiration. Sackages frozen hamburgers, French Fries should be closed air exposure and dated when The fryer area, including the dhave been cleaned after its is evening. Stall baking pans should be air ck and stacked only after they by. Sed Food Receiving and sprovided by the 13/25 at 1:23 PM indicated ther staff should always a storage areas. The policy ored in the refrigerator or overed, labeled and dated with Sed Preventing Foodborne ing, dated 12/09 provided by in 5/13/25 at 1:23 PM indicated ipment should be sanitized		CROSS-REFERENCED TO THE APPROPRIA	AIE
A current policy titled Dishwashing Machine Use, dated 8/10 indicated after running items through		A current policy titl	ed Dishwashing Machine Use,			

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	OF CORRECTION	IDENTIFICATION NUMBER 155364	A. BUILDING B. WING	00	COMPLETED 05/19/2025
	ROVIDER OR SUPPLIER		1661 B	ADDRESS, CITY, STATE, ZIP COD BEACON STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0000	the dishwasher, the dry. 3.1-21(i)(2) 3.1-21(i)(3)	items should be allowed to air			
Bldg. 00	Survey. This visit in State Licensure Survey Survey dates: May 1 Facility number: 000 Residential Census: Byron Health Cente compliance with 410 State Residential Lice	13, 14, 15, 16 and 19, 2025. 0255 47 r was found to be in 0 IAC 16.2-5 in regard to the	R 0000	This Plan of Correction is Byr Health Center's credible alleg of compliance. It is the intent of Byron Health Center to be complete compliance with all Federal and State guidelines. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the state deficiencies. plan of correction is prepared and/or executed because the provisions of federal and state 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 bee affected by the deficient practice? All nursing staff who administ medication will be educated of ensuring dignity is maintained during medication administrat specifically during meal time.	ation ion iin of ot ment the et The elaw II n er on

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PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	î í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
MADIDAN	or condition	155364	B. W.			05/19/	
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD EACON STREET		
BYRON I	HEALTH CENTER		FORT WAYNE, IN 46805				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE			(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	REGULATORT OF	LIST IDENTIFY FING INFORMATION		TAG	(F550 Attachment 1).		DATE
					How other residents having	the	
					potential to be affect by the		
					same deficient practice will	be	
					identified and what corrective	re	
					action(s) will be taken.		
					All residents who are adminis	tered	
					medication had the potential t		
					affected. All nursing staff who		
					administer medication will be	•-	
					educated on ensuring dignity		
					maintained during medication		
					administration, specifically du meal time. (F550 Attachment	-	
					What measures will be put in		
					place or what systemic	110	
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					Director of Nursing or her des	ignee	
					observe medication administra	ator	
					one time per week times six		
					months to ensure compliance		
					ensuring dignity during medic		
					administration. (F550 Attachr	nent	
					2).		
					Please specify how the QAP Committee will monitor this	ı	
					plan of correction, how ofter	,	
					and for how long? If less the	-	
					six months, how will the faci		
					ensure the plan remains in	-,	
					place?		
					Director of Nursing or her des	ignee	
					observe medication administra	ator	
					one time per week times six		
					months to ensure compliance	with	
					ensuring dignity during medic		
					administration. (F550 Attachr	nent	
					2).		

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME O	F PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD BEACON STREET	•
BYRON	N HEALTH CENTER			WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				Any issues identified during the audit process will be address immediately. Any corrective actions taken shall be reported the QAPI Committee during monthly meetings and the planewised, if warranted. By what date the systemic changes will be completed: June 19, 2025	ed to
				F 583– Privacy of Records What corrective action(s) whe accomplished for those residents found to have be affected by the deficient practice? All nursing staff who administ medication will be educated ensuring privacy is maintained (F583 Attachment 3). How other residents having potential to be affect by the same deficient practice will identified and what correcting action(s) will be taken. All residents who are administ medication had the potential affected. All nursing staff who administer medication will be educated on ensuring privacy maintained. (F583 Attachments)	ter on ed. the be ve stered to be o e y is
				What measures will be put in place or what systemic changes will be made to	into

State Form Event ID: KX8311 Facility ID: 000255 If continuation sheet Page 28 of 37

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2025					
	NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ensure that the deficient practice does not recur? Director of Nursing or her desi observe medication administra one time per week times six	DATE			
				months to ensure compliance ensuring privacy during medic administration. (F583 Attachn 4). Please specify how the QAPI Committee will monitor this plan of correction, how often and for how long? If less that	ation nent			
				six months, how will the faci ensure the plan remains in place? Director of Nursing or her desi observe medication administra one time per week times six months to ensure compliance ensuring privacy during medic	ignee ator with			
				administration. (F583 Attachn 4). Any issues identified during th audit process will be addresse Any corrective actions taken s be reported to the QAPI Committee during monthly meetings and the plan revised warranted.	e d. hall			
				By what date the systemic changes will be completed: June 19, 2025				

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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	(X3) DATE SURVEY COMPLETED 05/19/2025				
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
					II n is tor the be //e I the arses the ated e or 5). nto		

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PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155364	A. BUILDING B. WING	00 00	COMPLETED 05/19/2025
	ROVIDER OR SUPPLIER HEALTH CENTER		1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				the Bed Hold Policy to the resident or their representativ (F628 Attachment 6). 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 deside to audit each transfer or discriptor six months to ensure compliance with communication the Bed Hold Policy to the resident or their representativ (F628 Attachment 6). Any issues identified during the audit process will be addressed. Any corrective actions taken side reported to the QAPI Committee during monthly meetings and the plan revised warranted. By what date the systemic changes will be completed: June 19, 2025	n, an ility signee parge on of e. ne ed. shall

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PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/19/2025	
	ROVIDER OR SUPPLIER		1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				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 ensuring accurate and timely assessments are documented (F684 Attachment 7) How other residents having potential to be affect by the same deficient practice will lidentified and what corrective action(s) will be taken. All residents who experience change in conditions had the potential to be affected. All nustaff expected to initiate and document assessments will be educated on ensuring accurate and timely assessments are documented. (F684 Attachmen 7). What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or her desto audit documentation related assessments for 10% of reside monthly times six months to determine compliance with assessment and documentation (F684 Attachment 8). Please specify how the QAP Committee will monitor this plan of correction, how ofter	n don d. the be re de

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PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SU COMPLET 05/19/20	TED
	ROVIDER OR SUPPLIE		1661 B	ADDRESS, CITY, STATE, ZIP COD SEACON STREET WAYNE, IN 46805	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
				and for how long? If less six months, how will the ensure the plan remains place? Director of Nursing or her to audit documentation reassessments for 10% of monthly times six months determine compliance with assessment and docume (F684 Attachment 8). Any issues identified during audit process will be added and education will be given through one-on-one training corrective actions taken some reported to the QAPI Conduring monthly meetings plan revised, if warranted by what date the system changes will be completed June 19, 2025	e facility s in designee elated to residents' s to th ntation. Ing the ressed en to staff ing. Any shall be nmittee and the l. Inic ted:	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	- 1	ESURVEY LETED 0/2025
	ROVIDER OR SUPPLIE		1661 B	ADDRESS, CITY, STATE, ZIP CO BEACON STREET WAYNE, IN 46805	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
				practice? All nursing staff who ass placing and storing will educated on ensuring o stored appropriately wh use and within reach of when needed. (F 695 A 9). How other residents has potential to be affect be same deficient practice identified and what con action(s) will be taken. All residents on ordered had the potential to be at this practice. All nursing assist with placing and sible educated on ensuring is stored appropriately was and within reach of when needed. (F 695 A 9). What measures will be place or what systemic changes will be made ensure that the deficie practice does not recurbirector of Nursing or has audit the storage and placement of oxygen was ix months to determine compliance with proper and administration (F 69 Attachment 10). Please specify how the Committee will monito plan of correction, how and for how long? If le six months, how will the ensure the plan remain	be exygen is en not in residents ttachment aving the y the e will be rrective d oxygen affected by y staff who storing will g oxygen when not in residents ttachment e put into c to nt r? er designee leekly times e storage 95 e QAPI r this v often, ess than ne facility	

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AND PLAN OF CORRECTION	identification number 155364	A. BUILDING B. WING	00	COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPI BYRON HEALTH CENTE		1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			place? Director of Nursing or her desto audit the storage and placement of oxygen weekly the 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 through one-on-one training. corrective actions taken shall reported to the QAPI Committed during monthly meetings and plan revised, if warranted. By what date the systemic changes will be completed: June 19, 2025	imes ge ne ed staff Any be dee the

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD EACON STREET	
BYRON I	HEALTH CENTER			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORI UK	LISC IDENTIFTING INFORMATION	IAU	ensuring dishes are dried pric storage (F812 Attachment 11 How other residents having potential to be affect by the same deficient practice will identified and what correctivaction(s) will be taken. All residents who are served from the kitchen had the pote to be affected by this practice staff will be educated the proplabeling and dating of food, discarding expired food and ensuring dishes are dried pric storage (F812 Attachment 11 What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Dining Services or designee to review labeling a dating of food, ensure food is properly discarded and dishestored appropriately after bein washed via observation week times six months (F812 Attachment 12). Please specify how the QAP Committee will monitor this plan of correction, how often and for how long? If less the six months, how will the factorist months and dishestored appropriately after being dating of food, ensure food is properly discarded and dishestored appropriately after being stored appropriately after being store	the be ye food ntial All ber or to). nto her nd s are ng dy l n, an ility her nd s are

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMI		(X3) DATE S COMPL 05/19/	ETED	
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
				washed via observation weekl times six months (F812 Attachment 12). Any issues identified during th audit process will be addresse and education will be given to through one-on-one training. Corrective actions taken shall be reported to the QAPI Committed during monthly meetings and to plan revised, if warranted. By what date the systemic changes will be completed: June 19, 2025	e ed staff Any be ee		

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