STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FIVE STAR RESIDENCES OF FORT WAYNE	2601 COVINGTON COMMONS DRIVE FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for Investigation of Complaint IN00452174. Complaint IN00452174- Deficiencies realted tothe allegation are cited at R0053. Survey date: February 11, 2025 Facility number: 014017 Residential 75 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 12, 2025	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency Based on observation, interview, and record review the facility failed to ensure the safety and well-being of 1 of 3 residents reviewed. (Resident Q) Findings include: In an observation, on 2/11/25 at 10:22AM, Resident Q was crying while describing an incident related to a Qualified Medication Assistant (QMA) 6 referring to her as an "asshole". During an interview, on 2/11/25 at 10:41AM, Resident Q had difficulty recalling specifics that led to a QMA 6 calling her an asshole. Resident Q	R 0053	Residents with a BIMS of 10 or higher will be inteveiwed using QIS abuse questions. Any response indicating potential abuse or resident rights validation will be investigated and reported as appropriate. Abuse and resident rights will be reviewed at the next resident council meeting and as next family event. All staff will be re-education via intetactive table top discussion and report back on abuse, by March 3rd or will be off the schedule until to education is completed.	03/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carly Terhune	LPN/DRC	02/28/2025

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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	recalled using her call light several times and, in her words, frustrating QMA 6. Resident Q plainly remembered being referred to as "an asshole". Resident Q was unable to recall the QMA 6's name or any witnesses to the incident. After the incident, Resident Q indicated she was shocked and didn't know what to think or say. Resident Q was clear QMA 6 left the room without apologizing. However, later returned to apologize. Resident Q was aware the witness called the head nurse and reported the incident promptly. Resident Q indicated she was uncertain if QMA 6 would retaliate or how she would act if seen in the future. Resident Q indicated she never thought QMA 6 would talk to her like that to begin with. Although she denied being afraid, she indicated she was "very uncomfortable" when she saw QMA 6 return to work as she was not expecting for her to return to the facility. Resident Q indicated when she encountered QMA 6 she made sure to not even speak to her to prevent any retaliation or angering her further. A record review of Resident Q's chart began on 2/11/25 at 11:18AM. Resident Q's diagnoses included adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, and heart disease. Resident Q's care plan included needs for assistance with ambulation, bathing, wellness services, medication administration, meals, memory loss, and cognitive impairment. Resident Q's most recent BIMS (Brief Interview for Mental Status) assessment was completed on 4/18/24 at 3:25PM. Resident Q's score was 10. The score of 10 indicated moderate cognitive impairment.		Specific team member involved received a final written warning and performance will be monitored as follows: 5 residents receiving care on D.Dance new assignment will be interviewed regarding care to ensure no additional care concerns once a month for the next three months	

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	There was no documentation of the incident, any notifications, evaluations, or follow ups in Resident Q's medical record. In an interview, on 2/11/25 at 12:32PM, Resident Q's daughter indicated she felt referring to her mother as an asshole was abusive. Resident Q's daughter indicated her mother brought it up frequently, therefore she knows it really bothered Resident Q. Resident Q's daughter indicated she believes her mother had mental anguish over the language used and therefore it was verbal abuse. The facility's investigation provided by the Executive Director (ED) on 2/11/25 at 11:08AM was reviewed. The investigation included an interview with Resident Q on 1/28/25. The investigation indicated the ED told Resident Q she had the ability and right to provide input regarding if she believed the incident on 1/24/25 fell into verbal abuse or mental anguish categories. Resident Q confirmed she did believed the incident did fall into both categories. The Investigatory Interview Form was signed and dated by the ED. An Investigatory Interview Form, signed by QMA 6, dated 1/24/25 indicated- while she was in Resident Q's apartment applying first aid to her leg, I asked Resident Q chill out, becasue Iwas looking to make sure I got the right stuff for first aid, and there was no need to be an asshole. QMA 6 indicated she immediately apologized for her statement. QMA 6 was asked to describe what happened immediately after she apologized. QMA 6 indicated Resident Q told her it was okay, butQMA 6 shouldn't have been rude. QMA 6 indicated she and Resident Q chatted and had some laughs. Resident Q and QMA 6 had always had a good joking relationship and was able to			

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	laugh together A current Policy and Procedure titled, "Abuse, Neglect, and Exploitation Prohibition and Prevention Program dated 11/15/02, was provided by ED on 2/11/25 at 11:08AM. The policy indicated ... "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. Willful as used in this definition of abuse, means the individual must have acted deliberately; not that the individual must have intended to inflict injury or harm ...1. Verbal abuse ...use of terms that are reasonably understood to be disparaging and derogatory" ... The citation is realted to Complaint IN00452174.			