STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING _____ B. WING _____	C 02/19/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00427412, IN00427540, and IN00428400. This visit included the Investigation of Residential Complaint IN00426779. Complaint IN00427412 - Federal/state deficiencies related to the allegation are cited at F600. Complaint IN00427540 - No deficiencies related to the allegations are cited. Complaint IN00428400 - No deficiencies related to the allegations are cited. Survey dates: February 16 and 19, 2024 Facility number: 000255 Provider number: 155364 AIM number: 100273280 Census Bed Type: SNF/NF: 100 Total: 100 Census Payor Type: Medicare: 1 Medicaid: 95 Other: 4 Total: 100 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 20, 2024	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were free from mental and physical abuse by staff for 1 of 3 resident's reviewed (Resident D). The deficient practice was corrected on 2/1/24 prior to the start of the survey and was therefore past non-compliance. Findings include: A Indiana IDOH (Indiana Department of Health) incident report, dated 1/30/24 at 7:00 p.m., indicated the Administrator had viewed the facility camera, located on the male secured unit, for investigation of a staff members reported injury. The camera footage indicated at 5:04 a.m., QMA 2 walked into the nurse office followed by Resident D in his wheelchair. The resident was next seen on the floor outside the nurse office followed by his wheelchair coming out after him.	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

He got back into his wheelchair and left the area. QMA 2 was observed to follow Resident D and removed the backpack off the back of his chair. A struggle between the 2 ensued and QMA 2 swung the backpack at the resident. QMA 4 came into view and ran towards the area where QMA 2 and the Resident were struggling over the backpack. QMA 2 took the backpack and threw it over into the kitchenette. Around 5:10 a.m., LPN 5 (Licensed Practical Nurse) entered the video pushing a cart carrying blue pharmacy bins. She was observed to be pointing at the resident, and pushed the cart towards him. LPN 5 then went behind and moved the residents wheelchair towards the exit door to the courtyard where she tipped him forward towards the door. QMA 4, QMA 6, and LPN 5 were seen with the resident at the door while QMA 2 walked around holding her right wrist. The resident was observed to go behind the nurse station to get his backpack, then went out to his wheelchair. At 5:15 a.m., Resident D was observed back in his wheelchair, seated outside the nurse office where QMA 2, QMA 4, and QMA 6 appeared to be speaking to the resident. LPN 5 was observed drawing up medication into a syringe. At 5:20 a.m., QMA 4 moved behind the resident while QMA 2 and QMA 6 held the residents hands down on the arms of his wheelchair. LPN 5 administered the injection. After the medication was administered, Resident D was observed propelling himself down the hallway following the 4 staff members.

On 2/16/24 at 10:55 A.M., Resident D's record was reviewed. Diagnoses included Schizoaffective disorder, medication induced Parkinsonism, psychotic disorder with delusions, restlessness and agitation, anxiety disorder, and insomnia.

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F 600	Continued From page 3	F 600		

An admission MDS (Minimum Data Set) assessment, dated 1/31/24, was completed following an extended stay at an inpatient psychiatric hospital. The resident had no cognitive impairment and was responsible for himself. The assessment indicated he had hallucinations and delusions. He had physical behaviors 1-3 days, verbal behaviors 4-6 days, behaviors not directed towards others 4-6 days, and wandering 1-3 days. His behaviors had worsened since his last assessment and hospitalization. The resident was prescribed multiple psychotropic medications to control his behaviors, hallucinations, and delusions.

A behavior management plan of care, updated 2/13/24, indicated Resident D was physically and verbally aggressive towards staff and peers. He would grab at staff, block staff in areas, throw items, had intrusive behaviors such as interrupting conversations or talking over others, shadowing/following staff and peers, inappropriate usage of the phone (calling 911 to report delusional thoughts), name calling, yelling, screaming, and made excessive religious comments. At times he would refuse care and medications. The resident had visual and auditory hallucinations, would talk and respond to internal and unseen stimuli, talking in different voices. The behavior management plan of care had numerous interventions in place to keep the resident and his peers safe.

On 2/19/24 at 10:00 A.M., Resident D was observed off the secured unit, sitting in his wheelchair next to the receptionist desk where a staff member sat, providing 1:1 supervision. He was playing a religious program on his MP3

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F 600	Continued From page 4	F 600		

player, had an open bible sitting next to him on the counter, and was speaking profanities to himself.

On 2/19/24 at 10:45 A.M., the Administrator was interviewed. She indicated she interviewed Resident D on 1/30/24 at 3:00 p.m. He denied issues with staff and made comments about hitting women regardless of their color. When asked, he indicated he felt safe at the facility but had spent enough time here and it was time to move on. After viewing the video, the Administrator made several attempts to contact the 4 staff members involved in the incident to obtain statements. She was able to speak with 2 of the 4 employees including QMA 2 who alleged the resident had injured her wrist. The Administrator indicated all 4 employees were terminated on 1/30/24 before 5:30 p.m., their access to the facility and facility used media were terminated. There had been no reported concerns from residents, staff, or visitors regarding care provided by the 4 ex-employees prior to the incident on 1/30/24. The Administrator indicated the police were notified, she had spoken with IDOH CNA investigators and was fully cooperating with their investigation. Resident D was being monitored for psychosocial distress but hadn't had any change in behaviors or moods.

A current facility policy, provided by the Administrator on 2/16/24 at 10:30 A.M. and titled "Abuse Prevention Program", stated "Our residents have the right to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment and involuntary seclusion...."

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F 600	Continued From page 5 The past non-compliance deficiency began on 1/30/24 and deficient practice corrected on 2/1/24 after the facility terminated the 4 employees involved in the incident, reported the incident to local law authorities and IDOH as required. Resident D was immediately monitored and continued to be monitored for psychosocial distress related to the incident. The facility completed education with all staff on the abuse prevention program, compassion fatigue, and de-escalation techniques and handling of agitated residents. On 1/31/24 and 2/1/24, all staff were re-educated on the facility's abuse policy/procedure, de-escalation techniques, and educated on compassion fatigue. The facility monitored and will continue to monitor staff interaction with residents each shift x 4 weeks, then will continue to monitor daily until 100% compliance is reached. The results will be monitored through the facility QAPI plan. This tag relates to Complaint IN00427412. 3.1-27(a)(b)	F 600		