STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00431247. Complaint IN00431247 - Federal/State deficiencies related to the allegations are cited at F609. Survey dates: April 4, 2024 Facility number: 000282 Provider number: 155755 AIM number: 100287520 Census Bed Type: SNF/NF: 88 SNF: 5 Total: 93 Census Payor Type: Medicare: 6 Medicaid: 60 Other: 27 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 5, 2024	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including			

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

Steven Schaaf | HFA, V.P. Operations | 04/16/2024

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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	injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to enure an injury of unknown origin was reported for 1 of 3 residents reviewed (Resident D). Findings include: On 4/4/24 at 1:27 P.M., Resident D's record was reviewed. Diagnoses included dementia with behavioral disturbance. An IDT (Interdisciplinary Team) note, dated 2/26/24 at 11:00 a.m., indicated the resident was observed with swelling and discoloration of the right side of her face. She was not wearing her dentures becasue they were broken. The	F 0609	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. The injury of unknown etiology involving resident D was reported to the Indiana State Department of Health on April 5, 2024. This incident was investigated at the	04/24/2024

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	resident's family was notified of the swelling and broken dentures. The family member indicated too the IDT they were aware of the injury to her face and had taken her to the ER on 2/24/24 to be evaluated and treated. A late entry progress note dated 2/23/24 at 4:00 p.m., indicated the resident's right cheek and side of her face had been swollen without bruising. An IDT note, dated 3/23/24 at 12:27 p.m., indicated Resident D had swelling near and blue bruising below her right eye. She had no signs of discomfort or pain. Staff were interviewed by the facility about the swelling and bruising, but no one knew what had occurred. There was no further documentation in progress or event notes regarding the resident's injuries documentated on 2/23/24 and 3/23/24. There was no investigation into the cause, affect of injury on the resident or follow up for resolution of the injury. In an interview on 4/24/24 at 2:35 P.M., the Director of Nursing (DON) indicated staff had assumed the resident had fallen and had gotten herself back up in both incidents. Staff removed the resident's enabler bars to her bed and her nightstand to prevent fall with injury however, it was unknown whether her injuries were due to falls. She indicated neither she nor the Administrator reported the injuries observed on 2/23/24 or 3/22/24 but should have as the resident was unable to tell staff how they occurred, had no witnessed or reported falls, wasn't prescribed blood thinners, and the injuries had occurred to her face/head. A current policy, titled "Compliance with		time of its occurrence and the cause of the injury was determined with reasonable certainty and communicated to the family member of resident D. Incident reports involving injuries of unknown etiology over the past ninety (90) days in which 1) the source of the injury was not observed, 2) the source of the injury could not be explained by the resident or clinical condition, and 3) the injury meets criteria for being suspicious will be reviewed for reportability to the Indiana State Department of Health (ISDH). Any incident found to meet reportable criteria will be reported to ISDH. This task will be completed by licensed nursing leadership. The Administrator, Director of Nursing, Assistant Director Nursing, Community Nurse Leaders and Weekend Nurse Supervisor will receive in-service training on facility's policy, titled "Compliance with Reporting Abuse, Neglect, Exploitation." This in-service training will be provided by the Corporate Director of Clinical Operations. An audit of incident reports will be conducted seven (7) days a week for thirty (30) days, and then three (3) days a week for sixty (60) days. Audits will be conducted to determine if they meet criteria for	

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	Reporting Abuse, Neglect, Exploitation Policy" was provided at 2:37 P.M. by the DON which stated: "It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources...immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed times...d. Injuries of unknown source: Includes circumstances when both the following conditions are met; The source of the injury was not observed by any person or could not be explained by the resident. The injury is suspicious because of the extent of the injury, location of the injury...." This tag relates to Complaint IN00431247. 3.1-28(c)		reportability and are subsequently reported in a timely manner. The audits will be conducted by nursing leadership. A report of audit results will be forwarded to the Quality Assurance Committee to ensure the training and monitoring are effective. Further corrective action may be initiated by the Quality Assurance Committee based on its review of the report of the audits. If 100% compliance is not achieved with reporting of incidents by the end of the ninety (90) total day auditing period, then the audits will continue until 100% compliance is consistently achieved. The Quality Assurance Committee will continue to review the audits until such time that 100% compliance is achieved. April 24, 2024.	