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	03/12/2024

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 Complaints IN00428352, IN00428429 and IN00429037. This visit included the Investigation of Residential Complaints IN00428929 and IN00429177. Complaint IN00428352 - No deficiences related to the allegations are cited. Complaint IN00428429 - No deficiences related to the allegations are cited. Complaint IN00429037 - Federal/State deficiencies related to the allegations are cited at F580. Survey dates: March 11 and 12, 2024 Facility number: 000282 Provider number: 155755 AIM number: 100287520 Census Bed Type: SNF/NF: 90 SNF: 5 Residential: 43 Total: 138 Census Payor Type: Medicare: 16 Medicaid: 56 Other: 23 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 13, 2024	F 0000		

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

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

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	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician and family timely of a significant change in condition for 1 of 1 residents reviewed (Resident D). Findings include: On 3/11/24 at 10:57 A.M., Resident D's family member/POA (Power of Attorney) was interviewed. The family member indicated the resident had been admitted to the facility following hospitalization for C. Diff colitis (Clostridium Difficile infection of colon). She had completed her therapy and family was waiting until her C. Diff infection was completely resolved to take her home due to home health refusing to provide care at home with an active C. Diff infection. The POA alleged on 12/25/23, another family member had been in to visit the resident. Reidnet D complained of right sided pain in her midsection. The family indicated they did not inform the facility. On 12/27/23, 2 other family members visited and the resident was observed to grab at her right side and stated "oh that hurts". Family asked staff to assess the resident and inform the doctor or NP (Nurse Practitioner) of the pain. The staff member was alleged to have put the resident's name on the NP list to be seen at the	F 0580	Resident D discharged to home. The IDT notes from March 1, 2024 forward of all residents will be reviewed to ensure that the Resident/Responsible Party and Physician have been notified of any significant change of resident condition. Notification will be made immediately for any significant change of condition which does not include supporting documentation indicating such notification. This task will be completed by nursing leadership. All Licensed Nurses and Qualified Medication Aides will receive in-service training on the “Notification of Changes” policy. This in-service will be provided by the Assistant Director of Nursing/designee. Audits will be completed to ensure all significant changes of condition	04/09/2024

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	next scheduled visit. On 12/29/23, a family member contacted the DON (Director of Nursing). The DON indicated she hadn't been aware of the right sided pain Resident D had been having and she was unable to find documentation of the NP visiting her to assess the pain. On 12/31/23, family members came in to visit. Resident D was observed lying in bed, on her right side, in a fetal position. She was lethargic and only responded with mumbles. The family members observed an isolation cart outside the resident's room and asked a CNA (Certified Nurse Aide) why the cart was outside the room. They indicated the CNA hadn't known why the cart was there but thought it was due to the resident having "diarrhea". The family asked to speak with the nurse. QMA 2 (Qualified Medication Aid) indicated to the family there was nothing wrong with Resident D. The QMA indicated the resident was having diarrhea and at some point, she was put into isolation. LPN 3 was informed by the family about the concerns with the Resident D's right sided pain, lethargy and diarrhea. The family requested the resident be sent to the hospital for evaluation. The POA indicated the facility hadn't notified the family Resident D was having diarrhea, had been placed in isolation and indicated niether the physician nor the NP were notified of her symptoms until family came in and asked for her to be sent to the hospital. The POA indicated the resident was hospitalized 12/31/23 until 1/8/24 and hadn't returned to the facility per family's wishes. On 3/12/24 at 10:22 A.M., Resident D's record was reviewed. Diagnoses included Alzheimer's dementia and C. Diff colitis. An admission MDS (Minimum Data Set) assessment, dated 11/16/23, indicated the resident had severely impaired cognition.		are reported to the Resident/Responsible Party and Physician. The audits will be completed five days a week for thirty days, then weekly over sixty days. If 100% scoring on audits is not achieved by sixty days, auditing will continue until 100% scoring is achieved. The audits will be completed by nursing leadership. Completed audits will be forwarded to the Quality Assurance Committee to ensure the additional training and monitoring are effective. The Quality Assurance Committee will review the audits for a minimum period of six months or longer if 100% scoring on audits is not achieved. The Quality Assurance Committee meets quarterly. The Quality Assurance Committee will initiate additional corrective action, potentially including additional staff training, counseling, or expanded audit frequency if a trend of non-compliance with the "Notification of Changes" policy is identified.	

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A Discharge Summary, dated 11/27/23, indicated Resident D's expected date of discharge would be 11/30/23 following discharge from therapies. Her diarrhea had improved however, staff reported Resident D had loose, malodorous stools containing mucous, occurring over 11/25/23 through 11/26/23. An order to check for C. Diff was given and a sample was obtained on 11/28/23. The stool culture was positive for C. Diff. Resident D was prescribed a 10 day course of antibiotics beginning 12/4/23.

An NP progress note, dated 12/14/23, indicated Resident D had been seen for a post acute care visit. The resident had a history of C. Diff and had been taking Vancomycin (antibiotic) with the last dose scheduled for 12/15/23. She was waiting to go home until her C. Diff infection was resolved as home healthcare wouldn't accept her with an active C. Diff infection. Assessment and Plan indicated C. Diff: resident had a known history of C. Diff and had been on a course of Vancomycin. She would likely undergo testing to assess resolution of the infection. Her return home had been delayed due to concerns from home healthcare about C. Diff infection so ensuring resolution of the infection would be crucial for her transition back home. Staff were to notify the NP of any acute changes in conditions, concerns, or needs.

An NP progress note, dated 12/27/23 indicated the resident was seen for chronic care follow up. Resident D's C. Diff infection had resolved on 12/19/23, she had formed stools and was awaiting discharge. Both the resident and staff denied any acute concerns or needs at the time of the visit. The note indicated the resident should continue to be monitored for signs of C. Diff recurrence

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	following completion of antibiotics on 12/15/23. The NP progress note, dated 12/27/23, hadn't indicated the NP was aware of the resident's complaint of right sided flank pain or the family's voiced concerns. Nurse notes, dated 12/31/23 indicated the following: -10:10 a.m., the resident was having mucous like stools which had an odd odor. -2:37 p.m., the resident was resting in bed. She'd had very loose stools with mucous and unusual odor. -3:05 p.m., the family was in and wanted the resident sent to the hospital. The on-call NP was notified and orders given to transport to the hospital for evaluation. "Family all came in her room even though was aware of possible C. Diff". On 3/12/24 at 1:25 P.M., QMA 2 was interviewed. She indicated she recalled the resident had complained of back pain but she hadn't observed any obvious injury. She couldn't recall details but indicated if concerns had been reported to her, she would've told the nurse and either she or the nurse would put the request to be seen by the NP in the NP folder for the next visit. She indicated QMA's don't place isolation carts outside resident's rooms as nurses make determinations about isolation. On 3/12/24 at 1:49 P.M., LPN 3 was interviewed. She indicated she was the weekend supervisor who was in charge on 12/31/23. She hadn't put the resident into isolation and assumed Resident D had been placed in isolation the week. She indicated she had been going to notify the family of the resident's loose stools but hadn't had a chance to call either the family or the NP prior to the family's visit. LPN 3 indicated she had not			

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	been told Resident D had loose stools or she was in isolation for suspected C. Diff infection. She hadn't recalled the resident complaining of pain however, she had complained of being tired and she had adamantly refused to eat her lunch. On 3/12/24 at 2:30 P.M., the Director of Nursing (DON) was interviewed. She was able to review Resident D's bowel movement chart. The chart indicated the resident had loose stools on day shift on 12/30/23. There was no documentation to indicate the NP or family had been notified. The DON indicated if the resident had been having loose stools and put back into isolation, the doctor or NP and family should've been notified. A current policy, provided by the Assistant Director of Nursing on 3/12/24 at 3:06 P.M. and titled "Notification of Changes", stated the following: "The purpose of the policy is to ensure the campus promptly informs the residents, consults the resident's physician and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification...Circumstances requiring notification include...Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include...clinical complications...." This tag relates to Complaint IN00429037. 3.1-5(a)(2)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaints IN00428929 and IN00429177. This	R 0000		

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	visit included the Investigation of Nursing Home Complaints IN00428352, IN00428429, and IN00429037. Complaint IN00428929 - No deficiencies related to the allegations are cited. Complaint IN00429177- No deficiencies related to the allegations are cited. Survey dates: March 11and 12, 2024 Facility number: 000282 Residential Census: 43 Golden Years Homestead was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaints IN00428929 and IN00429177. Quality review comopleted March 13, 2024			