STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING _____ B. WING _____	C 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS	**7843 W JEFFERSON BLVD FORT WAYNE, IN 46804**

(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 Investigation of Complaint IN00445849. Complaint IN00445849 - Federal/State deficiencies related to the allegations are cited at F600. Survey date: November 6, 2024 Facility number: 004945 Provider number: 155756 AIM number: 200814400 Census Bed Type: SNF/NF: 87 SNF: 13 Total: 100 Census Payor Type: Medicare: 13 Medicaid: 67 Other: 20 Total: 100 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(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	F 600		

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

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F 600	Continued From page 1 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 interview and record review, the facility failed to ensure a resident's right to be free from physical abuse was protected for 1 of 3 resident's reviewed (Resident B). The deficient practice was corrected on 10/24/24 prior to the start of the survey and was therefore past non-compliance. Findings include: An Indiana Department of Health (IDOH) incident report, dated 10/22/24 at 6:20 p.m., indicated the Administrator had been notified, Certified Nurse Aid 5 (CNA) had made contact with Resident B while he had been combative with staff. The resident's safety had been insured and he was provided quiet space. CNA 5 was immediately sent home and removed from the schedule pending investigation. On 11/6/24 at 11:06 A.M., Resident B's record was reviewed. Diagnoses included severe dementia with behavioral disturbance, mood disorder, and restlessness and agitation. A quarterly Minimum Data Set (MDS) assessment, dated 10/7/24, indicated the resident	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

had severely impaired cognition. He required moderate to fully dependent care from staff for his activities of daily living. He resided on the secured memory care unit and was prescribed a mood stabilizer for his behaviors.

A care plan, revised 10/15/24, indicated the resident had behavioral symptoms. He would hit staff when care was being provided and at times, had episodes of kicking, hitting, and grabbing staff's arms and fingers during care. The goal was for his behaviors to be altered with staff interventions. Interventions were: notify spouse to bring photo of herself to help calm him when he was agitated; allow resident time to calm; attempt care at a later time and with different care giver; and observe for indicators of pain.

A care plan, revised 10/15/24, indicated the resident displayed anxious behaviors and at times, would try to hit staff when told to sit down so he wouldn't fall. Interventions were: offer to lay down; medication per order; assist him to go for a walk when he appeared anxious and was attempting to stand on his own; assist him with activities of his interest as a distraction-he liked listening to oldies, eating snacks, and being outdoors; talk calmly to the resident and explain to him to sit down so he doesn't fall and redirect.

On 11/6/24 at 1:48 P.M., the Administrator was interviewed. She indicated, on 10/22/24, she had been notified by a staff member, they had witnessed an event. The Resident B had been agitated and hit CNA 5. CNA 5 then struck Resident B with an open hand on the back of his right shoulder while he was seated in the dining room. The Administrator came to the building, interviewed CNA 5 who indicated she was

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F 600	Continued From page 3	F 600		

assisting the resident to eat dinner when he had punched her in the stomach. She swatted him back as a reflex but had not intended to harm the resident. CNA 5 was suspended pending investigation. Resident B was assessed, found with no injury, and was monitored for psychosocial distress. The Administrator interviewed witnesses and reviewed video recording of the incident. A thorough investigation was conducted. This included skin assessments, interviews of residents on the memory care unit, staff interviews, and family member interviews who were frequent visitors to the unit. All staff were re-educated on managing aggressive behaviors and abuse and on 10/24/24.

A current facility policy, titled "Abuse Prohibition, Reporting, and Investigation", was provided by the Administrator on 11/6/24, and indicated: "It is the policy to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion...."

The past non-compliance deficiency began on 10/22/24 and deficient practice corrected on 10/24/24 after the facility suspended and then terminated CNA 5's employment and reported the incident to IDOH as required. Resident B was immediately assessed for injury and monitored for psychosocial distress related to the incident. The facility completed education with staff on managing aggressive behaviors and abuse.

This Citation relates to Complaint IN00445849.

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F 600	Continued From page 4 3.1-27(a)(1)	F 600		