STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	02/21/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00452850. Complaint IN00452850 - Deficiencies related to the allegations are cited at F689. Survey date: February 21, 2025. Facility number: 000255 Provider number: 155364 AIM number: 100273280 Census Bed Type: SNF/NF: 93 Residential: 49 Total: 142 Census Payor Type: Medicaid: 93 Other: 49 Total: 142 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 24, 2025	F 0000	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** **F689 – Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All team members will be educated on ensuring that residents are not left alone during an emergent situation. (Attachment 1). **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who are at risk for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Starcher	Executive Director/COO	03/08/2025

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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			falls could be affected by this practice. All team members will be educated on ensuring that residents are not left alone during an emergent situation. (Attachment 1). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All team members will be educated on ensuring that residents are not left alone during an emergent situation. (Attachment 1). **Please specify how the QAA Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Administrator or her designee to conduct quarterly emergency mock drills to ensure emergencies are responded to appropriately (Attachment 2) for a period of at least a year. Any issues identified during the drill will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** March 8, 2025	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review the facility failed to ensure fall prevention interventions were followed for 1 of 4 resident reviewed (Resident B). Findings include: A facility reported incident file was provided by the Executive Director on 2/21/25 at 10:15 AM. The file included the following: The file, dated 2/4/25, indicated around 6:40 PM, Certified Nurse Aide (CNA) 5 assisted Resident B in the shower. Resident B was in the shower chair, started to foam at the mouth and turned blue. CNA 5 ran out of the room, left the resident alone in the shower chair, and got help. Upon return, CNA 5 and Qualified Medication Aide (QMA) 4 found Resident B on the floor of the shower. CNA 5's statement, undated, indicated while she assisted Resident B with a shower, Resident B foamed at the mouth. CNA 5 indicated she ran to get the nurse and upon return found Resident B on the floor of the shower. CNA 5's statement also indicated she did not witness the fall as she had ran to get the nurse and then came back. CNA 5 indicated she had left Resident B alone in the shower chair. QMA 4's statement, undated, indicated she was alerted by CNA 5, Resident B had turned blue and foamed at the mouth. QMA 4 indicated when she entered the room, Resident B was observed on the floor of the shower. In at interview, on 2/21/25 at 11:35 AM, the Director of Nursing (DON), indicated CNA 5	F 0689	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** **F689 – Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All team members will be educated on ensuring that residents are not left alone during an emergent situation. (Attachment 1). **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who are at risk for	03/08/2025

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	assisted Resident B with a shower in the shower chair. The DON indicated Resident B started to foam at the mouth and turned blue. The DON indicated CNA 5 left Resident B alone in the shower chair and ran to get assistance. The DON indicated when CNA 5 and QMA 4 returned to the room, Resident B was on the floor. The DON indicated Resident B had an unwitnessed fall while CNA 5 was out of the room. In an interview, on 2/21/25 at 11:25 AM, QMA 7 indicated when a resident was in the shower chair, the resident should never be left alone. QMA 7 indicated when additional assistance was needed, the call light should be pulled or staff yell out for help. QMA 7 indicated she would never leave the resident alone. In an interview, on 2/21/25 at 11:08 AM, CNA 6, indicated a resident was never left in the shower chair alone. CNA 6 indicated when a resident became unresponsive or had a change in condition while in the shower, she pulled the call light or yelled for help. Resident B's record was reviewed on 2/21/25 at 10:54 AM. Diagnosis included: history of a traumatic brain injury, muscle weakness, and quadriplegia. A quarterly fall assessment, dated 11/20/24, indicated Resident B was at high risk for falls. A current care plan indicated Resident B had a history falls due to a traumatic brain injury. The care plan indicated Resident B needed assistance with transfers and showers. A policy, dated 10/2005, titled "Falls - Clinical Protocol," was provided by the DON on 2/21/25 at		falls could be affected by this practice. All team members will be educated on ensuring that residents are not left alone during an emergent situation. (Attachment 1). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All team members will be educated on ensuring that residents are not left alone during an emergent situation. (Attachment 1). **Please specify how the QAA Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Administrator or her designee to conduct quarterly emergency mock drills to ensure emergencies are responded to appropriately (Attachment 2) for a period of at least a year. Any issues identified during the drill will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** March 8, 2025	

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	11:45 AM. The policy did not indicate fall prevention interventions for high fall risk residents. This citation relates to Complaint IN00452850. 3.1-45(a)			