STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Englewood Health & Rehabilitation Center	2237 Engle Rd Fort Wayne, IN 46809

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents' privacy and dignity by asking permission prior to entering residents' room for 4 of 13 residents reviewed. (Resident 18, Resident 17, Resident 34, Resident 40). Findings include: 1. During a medication administration observation on 8/14/24 at 7:38 AM, RN 3 entered Resident 18's room without knocking, announcing herself, or asking permission to enter. She proceeded to turn on his light and explain care she was to provide. Resident 18's diagnoses included stroke, heart disease, and dysphagia. Resident 18's BIMS (Brief Interview of Mental Status) most recent 7/17/24 score of 2 indicated a severe mental status deficit. 2. During a medication administration observation on 8/14/24 at 7:46 AM, RN 3 entered Resident 17's room without knocking or asking permission to enter. RN 3 did announce herself as she was walking into the room and tuned on the light, causing Resident 17 covered her head with her blanket. RN 3 announced the care she was to give. Resident 17's diagnoses included stroke, diabetes, adult failure to thrive, and heart disease. Resident 17's BIMS score was a 13 on 6/20/24 and indicated a minimal deficit in mental status. 3. During an interview on 8/14/24 at 11:12 AM during a resident council group interview, Resident 34 indicated the facility was her home. Staff did not respect her space. Resident 34 indicated staff frequently did not knock prior to walking into her room or if they knocked, they tapped once or twice and then entered. Resident 34's diagnoses included diabetes, heart disease, and kidney disease. Resident 34's BIMS score was 12 on 7/1/24 and indicated a minimal decline in mental status. 4. During an interview on 8/14/24 at 11:12 AM during a resident council group interview, Resident 40 indicated the facility staff just knocked on the door and then walked right in. There had been times they talked to her as if she was not an adult or was unable to understand English. Resident 40's diagnoses included heart disease, diabetes, arthritis, and sleep apnea. Resident 40's BIMS score was 14 on 6/16/24 and indicated minimal mental status deficit. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An ongoing observation and interview on 8/15/24 from 9:10 AM to 9:36 AM indicated the following: An unidentified CNA (Certified Nurses Aid) knocked and called the resident's name in room [ROOM NUMBER], then entered without waiting for permission to enter. During an interview, RN 2 indicated when entering residents' rooms, staff should knock on the door and wait for an answer. If no answer, one should announce themselves and slowly open door and ask permission to enter. In an interview with the administrator on 8/15/24 at 10:03 AM, she indicated the expectation was for all staff to knock wait for permission to enter whether the door was open or closed. A policy and procedure titled Resident Care Procedure #01: Initial Steps dated 8/2016 and last revised 11/2022, indicated the following: Knock and identify yourself before entering the resident's room. Wait for permission to enter the resident's room. 3.1-3(p)(1)