PRINTED: 09/08/2022 PPROVED 0. 0938-039

EPARTMENT OF HEALTH AND HUN	IAN SERVICES		FORM APPR
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COMPLETED

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219			A. BU B. WI	ILDING NG	00	COMPL 08/05/	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
MAJESTI	IC CARE OF SOUT	H BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	D BE COMPLETI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	This visit was for a Recertification and State Licensure Survey.  Survey dates: August 1, 2, 3, 4, and 5, 2022  Facility number: 000124 Provider number: 155219 AIM number: 100266750  Census Bed Type: SNF/NF:62 Total: 62  Census Payor Type: Medicare:8 Medicaid:54 Total:62  These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.  Quality review completed August 8, 2022  483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights		F 0000		We do not submit this plan of correction as admittance or denial of the alleged incidents. Please accept the following as a request for a desk review in lieu of of an onsite Post Survey Revisit. All consideration for a desk review would be much appreciated. If there are any additional documents that are needed, please reach out right away.		
F 0550 SS=D Bldg. 00							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETEI			
		155219	B. W				
				CTPEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	R			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND			H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		resident's individuality. The ct and promote the rights of					
	access to quality of diagnosis, severity source. A facility of maintain identical regarding transfer provision of service all residents regarding transfer provision of service all residents regarding transfer provision of service all residents regarding transfer in the resident has a citizen or resided §483.10(b)(1) The the resident can end without interference or reprisal from the §483.10(b)(2) The free of interference and reprisal from or her rights and the source.	y of condition, or payment must establish and policies and practices discharge, and the ses under the State plan for edless of payment source.  se of Rights. the right to exercise his or sident of the facility and as not of the United States.  e facility must ensure that exercise his or her rights be, coercion, discrimination, e facility.  e resident has the right to be e, coercion, discrimination, the facility in exercising his o be supported by the					
	required under thi	cise of his or her rights as subpart.  on and interview the facility	F 0:	550	F 550		08/26/2022
		rsonal privacy for 2 of 2		550	Resident Rights/ Exercise of	f	00/20/2022
	_	(Resident 112, Resident 110)			Rights		
					1. What corrective action(	s)	
	Findings include:				will be accomplished for the		
					residents found to have bee	n	
		on 8/1/22 at 9:22 AM, CNA 4			affected by the deficient		
	`	Assistant) was observed			practice;		
	_	12's room without knocking or			a. IDT team reviewed and		
		on to enter. CNA 4 went into			educated all staff on resident		
	Kesident 112's roon	n looked at the trash and			rights and Exercise of Rights.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155219	B. WING		08/05/2022	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	TH BEND	SOUTH BEND, IN 46635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	walked out. No ver	bal interaction was observed.		b. Education of all staff on		
				resident rights to dignified		
		n 8/1/22 at 10:14AM, the DNS		existence, self-determination,		
	,	g Services) was observed		communication with and acce		
	_	ent 112's room without		to persons and services inside	e and	
	knocking or asking	for entrance.		outside the facility.		
	In an observation of	n 8/2/22 at 9:11AM, QMA 6		2. How other residents		
		Assistant) was observed going		having the potential to be		
		room without knocking or		affected by the same deficie	nt	
		For entrance. Resident 112 and		practice will be identified and		
	his wife were prese			what corrective action(s) will		
	his wife were prese	nt in room visiting.		be taken;	•	
	In an observation of	n 8/2/22 at 1:34 PM, the MD		a. All residents have the		
		ntered Resident 112's room		potential to be affected by the		
		n the door or asking for		deficient practice. Full facility		
	1	lid not introduce himself to		on resident rights completed.	audit	
		s wife, who was present in the		on resident rights completed.		
	room.	is wire, who was present in the		3. What measures will be p	out	
				into place and what systemic		
	In an interview on 8	3/3/22 at 3:45PM, Resident		changes will be made to		
		did not knock on the door prior		ensure that the deficient		
	to entering.	•		practice does not recur;		
				a. Managers Daily rounds		
	2. In an observation	on 8/1/22 at 10:39 AM,		which are audited daily		
	Resident 110 return	ned from dialysis. CNA 4 was		accompanied by staff training.		
		ing on his door prior to		]		
		Resident 110 was on the phone		4. How the corrective		
	at the time of obser	_		action(s) will be monitored to	o	
				ensure the deficient practice		
	In an observation of	n 8/3/22 at 10:32AM, Resident		will not recur, i.e., what qual		
	110 return from dia	lysis. QMA 6 was observed not		assurance program will be p	- I	
	knocking on Reside	ent 110's door prior to walking		into place;		
	in. QMA 6 returned	to the room with water for		a. Weekly Qapi for the first	4	
	Resident 110, but d	id not knock or make presence		weeks, then monthly for 6 mon	nths,	
	known prior to wall	king into the room with the		and quarterly thereafter.		
	door closed.					
				5. Who is the "Team" that		
	In an interview on S	8/2/22 at 9:52 AM, the ED	1	will review and audit? Who		

(Executive Director) indicated staff should always

will oversee that the "Team" is

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155219		 UILDING	00	COMPL 08/05/	ETED	
	PROVIDER OR SUPPLIER		52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	A policy titled "Qua by Regional Nurse ( AM, stated5. Sta	nter any residents room and e residents' home.  Ality of Life-Dignity" provided Consultant on 8/4/22 at 9:46 ff are expected to knock and prior to entering residents'		conducting the audits and reviews as pledged?  a. All reviews and audits wi completed by the IDT team. THED/ DNS followed by the MDS SSD, Therapy Director, and UM Manager will ensure that all au and reviews are completed accurately and promptly.  6. By what date the system changes for each deficiency will be completed.  a. 8/26/2022	ne , nit udits	
F 0636 SS=D Bldg. 00	§483.20 Resident The facility must of periodically a communication standardized reproduced resident's fur §483.20(b) Compromers (b) Compromers (c) Comproment (c) Communication (c) Communicatio	Assessments & Timing Assessment onduct initially and prehensive, accurate, oducible assessment of nctional capacity.  whensive Assessments sident Assessment lity must make a sessment of a resident's goals, life history and of the resident assessment pecified by CMS. The include at least the ad demographic information tine. erns. n. avior patterns.				

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Event ID:

1P7M11

Facility ID: 000124

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	R MEDICARE & MEDIC					OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>00</u>	COM	TE SURVEY IPLETED 05/2022
	PROVIDER OR SUPPLIE		52654	T ADDRESS, CITY, STATE, ZIP CC 4 N IRONWOOD RD FH BEND, IN 46635	·D	
	T			1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE 'PROPRIATE	(X5) COMPLETION DATE
	problems. (ix) Continence. (x) Disease diagn (xi) Dental and nu (xii) Skin Condition (xiii) Activity pursu (xiv) Medications. (xv) Special treatu (xvi) Discharge pl (xvii) Documental regarding the addresses on the completion of the (xviii) Documental assessment. The include direct obs with the resident, with licensed and staff members on  §483.20(b)(2) What timeframes prescue chapter, a facility comprehensive a accordance with the paragraphs (b)(2) section. The time §413.343(b) of th CAHs. (i) Within 14 caler excluding readmis significant change or mental condition section, "readmis facility following a hospitalization or (iii) Not less than of	nosis and health conditions. utritional status. ns. uit. ments and procedures. anning. ion of summary information litional assessment care areas triggered by the Minimum Data Set (MDS). tion of participation in e assessment process must ervation and communication as well as communication nonlicensed direct care all shifts.  nen required. Subject to the ribed in §413.343(b) of this	F 0636	F 636		08/26/2022

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review the facility failed to ensure the accuracy of

Minimum Data Set (MDS) assessments in 2 of 16

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**Comprehensive Assessments** 

If continuation sheet

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CENTERS FO	OMB NO. 0938-039				
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155219	B. WING		08/05/2022
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIE	R	52654	N IRONWOOD RD	
MAJES	TIC CARE OF SOU	TH BEND	SOUTI	H BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ts reviewed. (Resident 45 and		What corrective action(s)	·
	Resident 112.)			will be accomplished for those residents found to have been	
	Findings include:			affected by the deficient	·
	Findings metade.			practice;	
	1. Resident 45 was	interviewed on 08/01/22 at		a. IDT team reviewed and	
		sident indicated he was missing		audited all residents'	
	teeth.			comprehensive assessments t	.0
				ensure accurate dental and	
	An observation wa	s made of Resident 45 teeth by		demographic MDS coding.	
	the DON on 08/04	/22 at 11:35 AM. The DON			
	indicated the reside	ent's left back bottom teeth		2. How other residents havi	ing
	were missing.			the potential to be affected by	y
				the same deficient practice w	/ill
	The quarterly MDS	S dated 6/25/22 indicated under		be identified and what	
		ntal Status L0200 Dental was		corrective action(s) will be	
		2 at 10:33 AM. The only		taken;	
	_	d in L0200 Dental were A.		a. All residents have the	
	1	fitting full or partial denture		potential to be affected by the	124
		uncleanable, or loose) and F. in, discomfort or difficulty with		deficient practice. Full facility a	
	_	interim MDS coordinator. The		of all residents' comprehensive assessments to ensure accura	
		ral/Dental Status L0200 Dental		dental and demographic codin	
		ndicate no natural teeth or		dental and demographic count	9.
	tooth fragments (ed			3. What measures will be po	ut
		,		into place and what systemic	
	The Regional Nurs	se Manager was interviewed		changes will be made to	
	8/4/22 at 11:30 AN	A. He indicated the resident's		ensure that the deficient	
	MDS Section L Or	ral/Dental Status L0200 Dental		practice does not recur;	
	charting would be	incorrect if the resident had		a. IDT team will review and	
	missing teeth.			audit all residents' MDS coding	<b>j</b>
				weekly x4, monthly x6, and	
		ursing Serves (DNS) was		quarterly thereafter.	
		/22 at 12:10 PM. She indicated			
		Section L Oral/Dental Status		4. How the corrective	
		incorrect and should show teeth		action(s) will be monitored to	
	I missing. She indicate	ated the resident did not have	1	ensure the deficient practice	

partial dentures, and had refused detal services.

2. Resident 112 was observed on 08/02/22

into place;

will not recur, i.e., what quality assurance program will be put

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155219 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 11:48AM. The resident was black/African IDT team will review and American, Resident 112 indicated he identified as audit all residents' MDS coding being African American. weekly x4, monthly x6, and quarterly thereafter. The Admission MDS dated August 2, 2022 indicated under Section A1000 Race/Ethnicity the 5. Who is the "Team" that resident was white. will review and audit? Who will oversee that the "Team" is The ED (Executive Director) was interviewed on conducting the audits and 8/4/22 at 11:12 AM. The ED indicated the resident reviews as pledged? was African American and the MDS would be All reviews and audits will be corrected. completed by the IDT team. The ED/ DNS followed by the MDS, A policy for MDS assessments was requested SSD, Therapy Director, and Unit from the ED on 8/4/22 at 11:50 AM. A policy, Manager will ensure that all audits entitled "Care Area Assessment" last revised and reviews are completed November 2019 by MED-Pass, Inc. was provided accurately and promptly. by the Regional Nurse Manager on 8/4/22 at 12:13 PM. The policy indicated "Care Area 6. By what date the systemic Assessments (CAAs) are used to help analyze changes for each deficiency data obtained from the MDS ..." No policy was will be completed. provided by the facility concerning MDS 8/26/2022 assessment accuracy prior to exit of facility. 3.1-36(c)(5)F 0684 483.25 SS=D Quality of Care Bldg. 00 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the

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comprehensive person-centered care plan,

review the facility failed to ensure adequate blood

Based on observation, interview and record

and the residents' choices.

Event ID:

1P7M11

F 0684

Facility ID: 000124

F 684

**Quality of Care** 

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  08/05/2022	
	PROVIDER OR SUPPLIEF		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	sugar check practic	es to ensure accurate readings		1. What corrective action(s	)
	for 1 of 1 resdient r	reviewed. (Resident 3, Resident		will be accomplished for thos	se e
	114)			residents found to have been	
				affected by the deficient	
	Findings include:			practice;	
				a. Education of all nursing st	•
	, ,	vation at 7:55AM on 8/2/22,		on Quality of Care for all reside	ents.
		oplies for a blood sugar check.		b. Full facility audit of all	
	1	ves, wiped Resident 3's finger		residents on accu-checks	
		the finger with a lancet, the put		completed.	
	_	the test strip inserted onto		1	
	the resident's finger. LPN 2 did not give the			2. How other residents	
	alcohol time to dry. LPN 2 used the first drop of			having the potential to be	
		k. After the measurement was		affected by the same deficien	
	_	the alcohol wipe across		practice will be identified and	
	Resident 3's finger	again.		what corrective action(s) will	
	2) D : 1			be taken;	
		vation on 8/2/22 at 8:42AM,		a. All residents have the	
	_	pplies for a blood sugar check.		potential to be affected by the	
		room, it was observed Resident		deficient practice. The nursing	
		gan eating breakfast. LPN 2 wiped Resident 114's index		management team audited all	
		-		residents on accu-checks.	
	1 -	on the pad of the finger, stuck ne finger with a lancet, then put		2 What massures will be a	
	_	n a test strip inserted onto the		3. What measures will be p into place and what systemic	•
	1 -	PN 2 did not give the alcohol		changes will be made to	
		used the first drop of blood		ensure that the deficient	
		er the measurement was read,		practice does not recur;	
		cohol wipe across Resident		a. The nursing managemen	, l
	114's finger again.	sonor wipe deross resident		team completed skills check of	•
	and a sum of a sum.			for all Nurse's and QMA's that	
	During an interview	v at 9:36AM on 8/2/22, LPN 2		perform accu-checks to ensure	•
	_	ot given training by facility		proper protocol is followed and	
		blood sugars accurately.		perform observations weekly.	
	A policy titled"Obt	aining a Fingerstick Glucose		4. How the corrective	
	Level" was provide	ed by DNS (Director of Nursing		action(s) will be monitored to	
	Services), on 8/2/22	2 at 3:27PM, indicatedThe		ensure the deficient practice	
	following equipmen	nt and supplies will be		will not recur, i.e., what qualit	ty

necessary when performing this procedure. 1.

assurance program will be put

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/05/2022	
	ROVIDER OR SUPPLIER		5265	ET ADDRESS, CITY, STATE, ZIP COD 64 N IRONWOOD RD ITH BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Disinfected blood g balls. 5test strip encourage and assis increase blood flow hand washing with Wash the selected fithe finger, with war alcohol is used to cl dry completely becareading. Repeated u	Wash cloth and towel. 3. ducose monitor. 4. 1-2 cottonSteps to procedure4. t resident, as needed, to to his or her fingers by brisk warm water and soap,7. ingertip especially the side of m water and soap. (note if ean the fingertip, allow it to tuse the alcohol may alter the se of alcohol may toughen the er first drop of blood if alcohol fingertip		into place; a. The nursing management team will perform a routine a residents on accu-checks on weekly (x4), monthly (x6), and quarterly basis.  5. Who is the "Team" that will review and audit? Who will oversee that the "Team conducting the audits and reviews as pledged? a. All reviews and audits and reviews as pledged? a. All reviews and audits and reviews as pledged? by the IDT team. ED/ DNS followed by the MD SSD, Therapy Director, and Manager will ensure that all a and reviews are completed accurately and promptly.  6. By what date the system changes for each deficiency will be completed. a. 8/26/2022	udit of a a d  t  " is  will be The DS, Unit audits
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin In §483.25(b)(1) Present Based on the come a resident, the fact (i) A resident receins professional standard pressure ulcers are pressure ulcers ure condition demonstation unavoidable; and (ii) A resident with				

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155219 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record F 0686 F 686 08/26/2022 review the facility failed to ensure prompt wound Treatments/ Services to assessment and treatment for 1 of 3 residents **Prevent / Heal Pressure Ulcers** reviewed. (Resident 112). 1. What corrective action(s) Findings include: will be accomplished for those residents found to have been Resident 112's record review began on 8/1/22 at affected by the deficient 12:19 PM. There were no wound assessment practice; under miscellaneous or evaluation tabs of the a. IDT team reviewed and records. Resident 112's diagnoses included audited all residents' non-pressure chronic ulcer to left leg, comprehensive assessments. pseudomonas infection, diabetes, and heart Education of all nursing staff disease. on wound assessments, preventions, and treatments. Resident 112 had orders dated 7/27/22 for active Full facility audit of all protein, pressure reduction devices, and Santyl residents on wound assessments dressing changes. Resident 112 was admitted on to ensure accurate and timely 7/26/22 with no treatments or medication orders documentation. until 7/27/22. How other residents Resident 112's admission assessment dated having the potential to be 7/27/22 indicated there was a wound to Resident affected by the same deficient 112's left heel. There was no description or practice will be identified and measurements of the wound documented upon what corrective action(s) will admission. be taken: All residents have the Resident 112's progress notes indicated a late potential to be affected by the entry by the DNS (Director of Nursing Services) deficient practice. Full facility audit entered on 8/2/22 at 11:47 with a service date of of all residents wound 7/27/22 at 11:45AM with a description of the assessments and treatments. wound. There were no measurements included. A nursing note on 7/27/22 at 16:15 (4:15 PM) What measures will be put documented as late entry indicated the into place and what systemic measurements of the wound were 7.4cm x 5.2cm. changes will be made to

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No depth was indicated. The wound was

classified as an unstageable ulcer on the left heel,

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ensure that the deficient

practice does not recur;

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		155219	B. W	ING		08/05/	2022	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			N IRONWOOD RD			
MA IEST	IC CARE OF SOUT	TH REND			BEND, IN 46635			
IVIAJEST	- CARL OF SOUT	TI DEND		30011	- DEND, IN 40033			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	E PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	but there was no other description provided.				a. IDT team will review and			
					audit wound assessments dail	у		
	During an interviewon 08/02/22 at 11:09 AM, the				and after admission on the ne	xt		
	DNS indicated a provider had not seen the wound				business day.			
	yet. The DNS indicated wound assessments were							
		st week the rounding wound			4. How the corrective			
		er) was unable to view the			action(s) will be monitored to			
		of time on 7/27/22. The DNS			ensure the deficient practice			
		vas in the facility and would			will not recur, i.e., what quali	- 1		
	assess the wound.				assurance program will be p	ut		
	Duning on absorption	ion and interview on 8/2/22 at			into place;			
	During an observation and interview on 8/2/22 at 1:30 PM, the facility MD (Medical Doctor),				a. IDT team will review and			
	· ·	ere for an initial visit for			audit wound assessments dail	•		
		MD indicated the wound was			and after admission on the ne	XI		
		2's heel but on his left ankle.			business day.			
		sident's foot down on a towel,			5. Who is the "Team" that			
	_	NS (Director of Nursing			will review and audit? Who			
		me in to reapply the dressing.			will oversee that the "Team"	ie		
	The MD did not me				conducting the audits and	15		
	The MB did not me	district the would.			reviews as pledged?			
	A review of Reside	nt 112's MD note dated 8/2/22			a. All reviews and audits w	ill he		
		nted the wound on the left			completed by the IDT team. T			
	lower calf with a 3c	em open ulcer. The ulcer had			ED/ DNS followed by the MDS			
		ote from the NP (Nurse			SSD, Therapy Director, and U			
		8/3/22 at 3:32 indicated the			Manager will ensure that all au			
	· · · · · · · · · · · · · · · · · · ·	nt was 7.11cm length x 4.12cm			and reviews are completed			
	width x 0.3cm dept	_			accurately and promptly.			
	_							
	During an interview	v on 8/4/22 at 3:12 PM, the			6. By what date the systen	nic		
	Regional Nurse Con	nsultant indicated the wound			changes for each deficiency			
	should have been d	escribed and measured on			will be completed.			
	admission in the ad	mission paperwork, and			a. 8/26/2022			
	Resident 112 should	d have been seen by the						
	wound NP on 7/27/	722.						
		und care" provided by the						
	_	nsultant on 8/4/22 at 3:12 PM,						
		nentation6. All assessment						
	data (i.e., wound be	ed color, size, drainage, etc.)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED				
		155219	B. W	ING		08/05/2022	
	PROVIDER OR SUPPLIER			52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0688	the Regional Nurse PM, indicated reside assessment complet Prevention3. A he completed by a licer admission/re-admiss	n management" provided by Consultant on 8/4/22 at 3:12 ents will have a skin ed upon admission ad-to-toe assessment will be					
SS=D Bldg. 00	§483.25(c) Mobilit §483.25(c)(1) The resident who enter range of motion do reduction in range resident's clinical of that a reduction in unavoidable; and	facility must ensure that a rs the facility without limited pes not experience of motion unless the condition demonstrates range of motion is					
	motion receives approvent further deceives appropriate assistance to mair with the maximum unless a reduction						
	treatment was provi		F 00	688	F 688 Increase/ Prevent Decrease i ROM/Mobility  1. What corrective action(s		08/26/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
		155219	B. W	ING		08/05/2022
27.12				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	C .		52654 1	N IRONWOOD RD	
MAJEST	IC CARE OF SOUT	TH BEND		SOUTH	H BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	Findings include:				will be accomplished for those	
	TE1 1' ' 1 1	CD 11 440 1 1			residents found to have beer	ו
		of Resident 40 was reviewed			affected by the deficient	
	indicated diagnoses	AM. Resident 40's record			practice; a. IDT team reviewed and	
	hemiparesis followi					nto
	_	rrhage affecting her left			audited all residents using spli	
		contracture of left hand,			to ensure accurate care-plans	and
		cation deficit, altered mental			orders	
	_	assistance with personal care.			2. How other residents	
	status and need 101	assistance with personal care.			having the potential to be	
	Resident 40's curre	nt Care Plan was reviewed on			affected by the same deficier	nt
		M. The Care Plan indicated a			practice will be identified and	
		focus was initiated 7/1/21			what corrective action(s) will	
	related to the reside				be taken;	
		ed functional range of motion			a. All residents have the	
	_	a. Specific interventions of the			potential to be affected by the	
		to apply a splint for up to 2-4			deficient practice. Full facility a	audit
	_	ist twice daily, monitor for and			of all residents using splints.	
		es related to the splint			cram residents demig spinner	
		r skin condition under the			3. What measures will be p	out
		reas of concern and provide			into place and what systemic	
		to application and upon			changes will be made to	
	removal of the hand				ensure that the deficient	
		•			practice does not recur;	
	The MDS coordina	tor was interviewed on 8/2/22			a. IDT team will review and	
	at 11:03 AM. She i	indicated per the Action of Care			audit all residents using splints	s
	Plan the resident wa	as to receive occupational			monthly x6 and quarterly	
	therapy (OT) three	(3) times weekly and would			thereafter.	
	wear a splint. She i	indicated the recommendations				
	were from therapy	on 9/21/21 and included a rest			4. How the corrective	
	hand on splint, a ro	ll style hand splint.			action(s) will be monitored to	
					ensure the deficient practice	
	The Rehabilitation	In-service Training Report			will not recur, i.e., what quali	
	dated 9/14/22 was r	received from the ED on 8/3/22			assurance program will be p	ut
	at 1:00 PM. The in	-service training report			into place;	
	indicated Resident	40's left hand splint training			a. IDT team will review and	
	was provided by Re	ehabilitation OT on 9/14/21 at			audit all residents on splints	
	8:45 to Majestic Ca	re South Bend staff.			monthly x6, and quarterly	
					thereafter.	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE ( A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2022		
	PROVIDER OR SUPPLIER	-	52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	The Occupational T 8/6/21 was received (ED) on 8/3/22 at 1 nursing was to take schedule, skin check Education was to be could them take over An observation was PM of Resident 40. Resident 40's left har resident was not we The Minimum Data reviewed on 8/3/22 indicated the resident Mental Status (BIM interviewable. The Treatments, Proced the resident did not In an interview on 8 of Nursing Services wear a splint. She forder for the resident The current medical 8/2/22 at 10:59 AM related to a left hand The current medical medical orders were 8/3/22 at 10:18 AM discontinued orders prior to exit of facil 3.1-42(a)(2)	Cherapy Progress Report dated I from the Executive Director 1:00 AM. The report indicated over the entire splint use ks and wash schedule. The provided to the staff so they er the splint wear schedule. The splint wear splint. The splint wear splint. The splint wear as plint. The splint wear as plint or brace. The splint wear as plint or brace. The splint wear as plint. The splint were reviewed on the splint. The splint were found displint. The splint were found displint. The splint were provided by the facility were provided by the facility were provided by the facility		5. Who is the "Team" tha will review and audit? Who will oversee that the "Team conducting the audits and reviews as pledged?  a. All reviews and audits of completed by the IDT team. ED/ DNS followed by the MD SSD, Therapy Director, and Manager will ensure that all a and reviews are completed accurately and promptly.  6. By what date the syste changes for each deficiency will be completed.  a. 8/26/2022	t " is will be The PS, Unit audits
F 0698 SS=F	483.25(I)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2022		
	PROVIDER OR SUPPLIER		STREET 52654 SOUTI		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	require dialysis reconsistent with propractice, the composite plan, and the preferences.  Based on observation review the facility of communication and residents receiving. Resident 7, Resident 7, Resident 7, Resident 11:54AM. Diagnost dependence on renastage renal disease.  Resident 110's physical to observe the dialysis welling, warmth, dislodgement every regarding dialysis properties for wireturn from dialysis. Resident 110's dialy report forms indicated to the properties of the president propertie	ensure that residents who believe such services, ofessional standards of orehensive person-centered residents' goals and on, interview, and record failed to ensure ongoing assessments for 4 of 4 dialysis. (Resident 110, tt 2, and Resident 6).  The ecord review began on 8/1/22 at est included heart disease, 1 dialysis, obesity, and end dician orders for dialysis were sist catheter site for redness, rainage, bleeding, and dressing shift. Resident 110 had orders ick up time, return time, and port. Resident 110 did not tals signs prior to or upon the exist and off communication or sist and off communication of the exist and off communication	F 0698	F 698 Dialysis 1. What corrective action(s will be accomplished for thoresidents found to have been affected by the deficient practice; a. Education of all nursing son both pre and post assessments of all dialysis residents b. Full facility audit of all residents on dialysis was completed. c. All assessments are completed using Point-Click-C (PCC) program.  2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a. All residents have the potential to be affected by the deficient practice. IDT team completed an audit of all dialy residents to ensure that pre are post assessments were completed.  3. What measures will be residents as the potential to be affected by the deficient practice.	se n staff care

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE	X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155219	B. WI			08/05/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					N IRONWOOD RD		
MAJESTI	C CARE OF SOUT	H BEND		SOUTH	I BEND, IN 46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	acility was blank with no nurse			into place and what systemic	;	
	signature, date, or ti	me.			changes will be made to		
					ensure that the deficient		
		orm had the resident name in			practice does not recur;		
	top portion. No other information regarding date,				a. IDT team will complete a	ın	
	code status, vitals, medication changes, fluid				audit of all dialysis residents		
	· ·	on of access site prior to			routinely. IDT team will use P0	CC	
	leaving for dialysis,	Covid 19 testing or			for all dialysis assessments.		
	vaccination status, a	and nurse signature were					
	blank. The section to be completed by the dialysis				4. How the corrective		
	unit did not have post dialysis weight, amount of				action(s) will be monitored to		
	fluid removed, vitals (temperature, pulse,				ensure the deficient practice		
	respiration, blood pressure sitting, and blood				will not recur, i.e., what quali	ty	
	pressure standing),	and amount of food or fluid			assurance program will be p	ut	
	consumed. There wa	as a signature and date on the			into place;		
	form provided by th	e dialysis unit. The return to			a. Weekly Qapi for the first	4	
	facility portion was	blank.			weeks, then monthly for 6 mor		
					and quarterly thereafter.		
	There was no comm	nunication form available for			. ,		
	dialysis treatments of	delivered on 7/29/22 or 8/1/22.			5. Who is the "Team" that		
	•				will review and audit? Who		
	The DNS (Director	of Nursing Services) provided			will oversee that the "Team"	is	
	reports from the dia	lysis center, faxed to the			conducting the audits and		
	facility on 8/2/22. T	he forms received included			reviews as pledged?		
	dialysis documentat	ion dated 7/27/22, 7/29/22, and			a. All reviews and audits wi	ill be	
	8/1/22. On the form	s, the only documentation			completed by the IDT team. T	he	
	reflected dialysis ca	re. There was no			ED/ DNS followed by the MDS	S,	
	documentation form	the facility on the records.			<u>-</u>		
	During an interview	on 8/3/22 at 9:42AM, the DNS			and reviews are completed		
	indicated the dialysi	is book was missing and she			accurately and promptly.		
	had requested medic	cal records get the					
	_	om the dialysis provider on			6. By what date the system	nic	
	8/2/22. It was late in	n the evening when the			changes for each deficiency		
		ed and the dialysis provider			will be completed.		
	•	IS indicated the nurse was			a. 8/26/2022		
	_						
	the information upo						
	8/1/22. On the form reflected dialysis ca documentation form:  During an interview indicated the dialysis had requested medic communications fro 8/2/22. It was late in request was submitt was closed. The DN responsible for ensu completed by the di	s, the only documentation re. There was no n the facility on the records.  on 8/3/22 at 9:42AM, the DNS is book was missing and she cal records get the om the dialysis provider on n the evening when the ted and the dialysis provider IS indicated the nurse was uring the section was alysis center and reviewing			completed by the IDT team. TO ED/ DNS followed by the MDS SSD, Therapy Director, and U Manager will ensure that all at and reviews are completed accurately and promptly.  6. By what date the system changes for each deficiency will be completed.	he S, nit udits	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/05/2022	
	PROVIDER OR SUPPLIER		52654 1	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAG	2) Resident 7's reco 11:49AM. Diagnost acquired absence (a dependence on renaidentified by the factor on the census sheet.  Resident 7's physici inspect the dialysis every shift, dialysis Tuesday, Thursday, changes to site as not days per week. Resident 7's physici inspect the dialysis. Tuesday, Thursday, changes to site as not days per week. Resident for vital signs dialysis. The resident included a discrepation of the dialysis was to be put dialysis was to be put on the dialysis was to be cone order indicated on Monday, Tuesday orders were active where the dialysis communicated on Monday at 12:04F unable to locate the as it was not where the dialysis until the enthe unit. Resident 7 the book was availated on 8/4/22 at 2:40 Put changed where the deginning on 8/3/22	rd review began on 8/3/22 at es included right, and left leg mputee), kidney failure, and al dialysis. Resident 7 was cility as able to be interviewed provided at survey entrance.  Itan's orders included to site for signs of infection pick up time (Monday, and Friday), dressing eeded, and resident dialysis 5 ident 7 did not have orders for ent prior to dialysis or upon visis. Resident 7 did not have an prior to or upon return from int's orders for dialysis incy regarding what days erformed, one order indicated completed 5 times a week and dialysis was to be completed by, Thursday and Friday. Both within the system.  PM, LPN 3 indicated she was dialysis communication book, it was normally stored.  M the Unit Manager indicated inication books were kept at do of the day, then returned to was in thier room resting, yet ble.  M LPN 3 indicated management dialysis books were kept.  2 they were relocated to the e. The floor nurse did not have	IAG	DATE NAME OF THE PARTY OF THE P	DATE
			ı	Ī	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/05/2022	
	PROVIDER OR SUPPLIER		52654 1	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	During an interview Manager indicated to books were currently them daily post dial. Unit Manager indicated to books were back on each night. She indicated to books were back on each night. She indicated the if somet dialysis books. The now kept all the books were the books are indicated. Dated 7/1/22 The first blank other than the code status, covid 1 status, mental status information, no assonursing signature. A report received. The been completed. The or no marked, the and the form was signally manager and the form was signally indicated to the completed. The section were blank that the treatment. Addition section were blank that the treatment was mental status, allerging the dialysis unit por return was checked non-applicable (n/a) section was blank. The covid status, allerging the dialysis unit por return was checked non-applicable (n/a) section was blank. The covid status are the covid status, allerging the dialysis unit por return was checked non-applicable (n/a) section was blank. The covid status are the covid status allerging the covid status allerg	on 8/4/22 at 3:25 PM, the Unit the dialysis communication y in her office as she checked ysis for completeness. The ated she ensured the dialysis the floor prior to her leaving cated staff knew how to hing was needed from the Unit Manager indicated she oks.  If communication report for the following:  The resident name and date. No 9 testing, Covid vaccine is, allergies, vitals, medication resement of access site, and no across the top was written: no be dialysis unit portion haad e upon return portion had yes additional comments were blank, in gned by the unit with no time indicated.  The resident name and date is not be completed by the unit with no time indicated missed all comments in the post without an explanation of why	TAG	DEFICIENCE	DATE
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, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED			ETED
		155219	B. WING 08/05/2022				
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			I IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND		SOUTH	BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	written with no time	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE!		DATE
	written with no time	e indicated.					
	Dated 7/6/22 pre dialysis portion missing covid						
	_	by QMA 6. Section to be					
	_	sis unit has line through and					
		issed treatment. Post dialysis					
		omments: missed treatment					
	_	ion signed with initials by Unit					
	•	ne and date designated area					
	_	ted and no time indicated.					
	Dated 7/7/22, the pr	re dialysis portion of the form					
	was missing covid information and allergies. the						
	form was signed by	QMA 6. The section to be					
	completed by the di	alysis unit had a line through					
	and was written over	er as a missed treatment. The					
	Post dialysis portion	n additional comments was					
	blank. The commen	its did not note missed					
	treatment or an exp	lanation for them. The section					
	was signed with the	initials of the Unit Manager.					
	In the time and date	designated area there was a					
	date noted but no tin	me was indicated.					
	Dated 7/8/22, the Pr	retreatment section was					
		mation and allergies. The					
	-	atheter) condition indicated a					
	· ·	e present. This section was					
		the DNS was unable to					
		tion completed by the dialysis					
	-	e unusual white patches and					
		the nursing signature. The					
	_	indicated a bruit and thrill					
		onal comments was blank. The					
		th the initials of the Unit					
		e but no time was indicated.					
	D . 15/11/22 1 -						
		Pretreatment section was					
	_	rmation and allergies. The					
		n indicated a bruit and thrill					
	were present. This s	section was signed with initials					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/05/2022		
	PROVIDER OR SUPPLIEF		52654	ADDRESS, CITY, STATE, ZIP CO N IRONWOOD RD I BEND, IN 46635	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPROPRIATE	(X5) MPLETION DATE
	completed by the d medications were g given to a facility s was not included. T bruit and thrill were was blank. The fort the Unit Manager w indicated.  Dated 7/12/22 the F covid information, medication information	ried by the DNS. The section ialysis unit indicated some iven and labs results were taff, but the title of the staff The return portion indicated a en/a and additional comments in was signed with initials by with a date but no time was determined by the pretreatment section missing mental status, allergies, attion, labs drawn, signs of				
	condition indicated applicable). This se by Unit Manager. I dialysis unit was coreturn portion agair n/and additional coinitials by Unit Mar	ion of access site. Access site bruit and thrill n/a (not section was signed with initials in section completed by simpleted entirely. The upon in indicated bruit and thrill were inments was blank, signed with mager. In the time and date re was a date noted and no				
	covid information sidentified by DNS a unit section had a lischeduled for dialy indicated under addinissed. Signed and Manager. In the time there was a date not 13th of July was a not scheduled for dialy dialy was a light of July was a light of J	reatment filled out without signed by initials unable to be as to name and title. Dialysis one through and indicated not sis today. Upon return portion litional comments treatment dated with initials by Unit are and date designated area ted and no time indicated. The Wednesday. Resident 7 was ialysis on Wednesdays.  pretreatment section was mation. The form had bruit and				
	_	d with yes and was signed with entials were indicated. The				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY PLETED 05/2022	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE	
	The Dialysis unit por return, additional co	to be identified by the DNS. ortion was completed. Upon omments was blank, bruit and d n/a and there was no time m.					
	line was crossed thin no report received a signature. The only was Resident 7's na unit portion was blacomments. The upobruit and thrill pressymptoms of infect	ass the pretreatment portion a grough and written on top was and it was without a nurse information in that section me and the date. The dialysis and under additional on return section identified ent as n/a, signs and ion was blank, additional and no time indicated.					
	had mental status as to all spheres), the of the condition of the bruit and thrill was of infection marked QMA 6. The dialys The upon return po- marked as n/a, addi the form was dated.	retreatment portion of the form is A&O x3 (alert and oriented covid information was blank, access site prior to leaving, present, signs and symptoms in o. The form was signed by its unit portion was complete. In the comments were blank, but there was no time ion of the form was signed by					
	status as A&O x3, 0 the condition of the bruit and thrill pres- symptoms of infect form was signed by portion was comple had bruit and thrill comments were bla	retreatment portion had mental Covid information was blank, access site prior to leaving, ent was marked yes, signs and ion was marked no, and the QMA 6. The dialysis unit etc. The upon return portion marked as n/a, additional nk, and no time was indicated.					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/05/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION		
TAG	Dated 7/22/22, the pwas blank, bruit and signed by an unread unit portion was corportion had bruit an additional comment indicated. The form Manager.  Dated 7/25/22, the pthrough and was wreceived. The dialyst comments were blatto indicate no reporreturn portion had badditional comment indicated. The form Manager.  Dated 7/26/22, the mental status as A& blank, condition of bruit and thrill press symptoms of infect dialysis unit portion written in additional comment of new orders. The signed by the Unit 1	pretreatment Covid information of thrill was marked as n/a, and lable signature. The dialysis implete. The upon return distribution of the dialysis implete. The upon return distribution of the dialysis is were blank, and no time is was signed by the Unit in the dialysis were blank, and no time is unit portion additional in the dialysis unit portion additional in the dialysis with a line marked through the had been received. The upon in the dialysis were blank, and no time was a was signed by the Unit in the dialysis was signed by the Unit in the dialysis was marked yes, signs and distribution was marked no. The in had please see new orders a comments. The upon return distribution was were blank without mention upon return section was	TAG				
	information blank, to prior to leaving brue yes, signs and symp no. The dialysis uni	the condition of the access site it and thrill present was marked otoms of infection was marked t portion was complete. The was blank with signature, and					

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/05/2022	
	PROVIDER OR SUPPLIER		52654 1	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	information blank, the prior to leaving brutyes, signs and sympton, and signed by at was unable to identiform. The dialysis unpon return portion n/a, the additional conthere was no time in portion was signed.  Dated 8/1/22, pretrestatus as A&O, covisigns were blank, the prior to leaving brutyes, signs and sympton, and the form was return portion had be the additional common was no time indicated was signed by the UD ated 8/2/22, the prout with code status condition of access dialysis, but no nurshad a line crossed the comment: error no funit portion was comportion had bruit an additional comment indicated. The form Manager.  Dated 8/3/22, the proportion had bruit an additional comment indicated. The form Manager.	re dialysis poriont was filled s, vitals, resident compliance, site prior to leaving for se signature. The information prough it and a written report received. The dialysis amplete. The upon return d thrill marked as n/a, as were blank, and no time was a was signed by the Unit			
	unreadable signatur had a line through i	nformation, and signed by an e. The Dialysis unit section t and and comment indicated t scheduled for dialysis on			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155219	B. WING		_	08/05/	2022
NAME OF P	DOUDED OF CUIPNITE		ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				I IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND	SOUTH BEND, IN 46635				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ` ` ` ` · · · · · · · · · · · · · · ·			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.  TAG DEFICIENCY)			COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)		DATE
		turn portion indicated under ts the resident doesn't receive					
		nesdays. The form was signed					
	and dated by the Ur	-					
	and dated by the or	nt ividinger.					
	Dated 8/4/22, the pr						
		the condition of the access site					
		it and thrill present was marked					
		otoms of infection was marked					
		as signed by a name with no					
		IS was able to identify the					
	person as an LPN. The dialysis unit portion was complete. The upon return portion had bruit and						
		the additional comments were					
		s no time indicated. The upon					
		signed by the Unit Manager.					
	retain portion was s	igned by the onit manager.					
	In an interview on 8	3/4/22 at 02:40 PM Resident 7,					
	indicated she goes t	o dialysis 4 days a week,					
	Monday, Tuesday,	Thursday, and Friday.					
		d she had to stop dialysis early					
	-	ood pressure drop. There was					
		of the incident in the dialysis					
	communication boo	k.					
	In an interview on §	8/5/22 at 8:36 AM, RN 7 (the					
		rse), indicated the blood					
	-	appened on 7/29/22 after one					
	-	e dialysis machine. She was					
	_	ne and monitored closely until					
		returned to normal. RN 7					
	-	nally took Resident 7 back to					
	her room after dialy	rsis and spoke with the staff.					
	3) During an intervi	iew on 8/4/22 at 2:48PM,					
		they were not allowed to					
		at dialysis. She indicated she					
		ecause dialysis was so early.					
		kes her medications prior to					
	going on an empty s	-					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155219 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Resident 2's record review began on 8/4/22 at 3PM. Diagnoses included end stage renal disease, dependence on renal dialysis, and cognitive communication deficit. Resident 2's physician's orders regarding dialysis included dialysis fistula check every shift for bruit and thrill, check fistula for pain, change in temp or bleeding, no blood pressures in left arm, dressing changes to site as needed, and resident dialysis 5 days per week. Resident 2 did not have orders for access site assessment prior to dialysis or upon returning from dialysis, vital signs prior to or upon return from dialysis, or a pick up time for dialysis. The dialysis hand off communication report for Resident 2 indicated the following: Dated 7/4/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion had a line drawn through and indicated the resident had missed the treatment. The upon return to facility portion indicated no assessment had been performed. A missed treatment was indicated in the additional comments. No information was provided as to whether treatment was refused, if resident was unable to do dialysis, or the reason for a missed session. Dated 7/5/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments was blank. The section was signed by the Unit Manager.

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Dated 7/6/22, the prior to dialysis portion had no covid information, no allergies, and was signed by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155219	B. W	ING		08/05/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND			BEND, IN 46635		
							<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		is unit portion was complete.					
	•	facility portion additional					
		nk, there was no assessment					
		igns of an infection. The					
	section was signed	by the Unit Manager.					
	Data d 7/7/22 tha m	sion to dialysis noution had no					
	Dated 7/7/22, the prior to dialysis portion had no covid information, no allergies, and was signed by						
	·	is unit portion had blank					
		ts. The upon return to facility					
	portion additional comments were blank. The section was signed by the Unit Manager.						
	section was signed	by the Chit Wanager.					
	Dated 7/8/22, the p	rior to dialysis portion had no					
	_	diet, compliance, medications,					
		ns filled out. The form was					
	_	with no indication of					
		lysis unit portion was					
		return portion had blank					
		ts and no time was indicated.					
		was signed by the Unit					
	Manager.	8					
	Ü						
	Dated 7/9/22, The p	prior to dialysis portion had no					
	covid information a	nd was signed by 2 letters					
	(initials) with no cre	edentials. The DNS was unable					
	to identify the signa	ture. Under additional					
	comments, lab resul	Its were given to a facility staff					
	with a lab value list	ed of Hgb 5.9 (low					
	hemoglobin). The u	pon return to facility portion					
	- '	ts were blank. There was no					
	acknowledgement of	of the lab value. The section					
	was signed by the U						
	Dated 7/10/22 The	top section was filled out code					
		s, fluid restrictions, medication					
	changes, medical pr	roblems since last dialysis, labs					
	drawn, access site a	ssessment bruit, thrill, and					
	signs of infection. A	At the top of the section a line					
	had been drawn thro	ough with the comment error					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/05/	ETED
	PROVIDER OR SUPPLIEI			52654 N	.DDRESS, CITY, STATE, ZIP COD I IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	•	The dialysis unit portion was owing dialysis portion was Manager.					
	covid information, QMA 6. The dialys through and indicat treatment. The upon indicated there was treatment in the add information was pro- was refused, if resid- or the reason for a re-						
	covid information, QMA 6. The dialys The upon return to	prior to dialysis portion had no no allergies, and was signed by is unit portion was complete. facility portion additional nk. The section was signed by					
	covid information, QMA 6. The dialys through with a com- the treatment. The indicated no assess the additional com- provided as to when	prior to dialysis portion had no no allergies, and was signed by is unit portion had a line drawn ment the residnet had missed upon return to facility portion ment with missed treatment in ments. No information was ther treatment was refused, if to do dialysis, or the reason n.					
	covid information, a first name withou The dialysis unit po return to facility po	prior to dialysis portion had no no allergies, and was signed by t credentials or a last name.  ortion was complete. The upon rtion additional comments were was signed by the Unit					

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Event ID:

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	ULTIPLE CO JILDING	INSTRUCTION 00	(X3) DATE COMPL		
		155219	B. WI	B. WING		08/05/2022	
	PROVIDER OR SUPPLIER			52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Dated 7/26/22, the provide information. Complete. The upon additional comments signed by the Unit Market Polymer of the provide information of the provide i	prior to dialysis portion had no The dialysis unit portion was a return to facility portion as were blank. The section was Manager.  prior portion was filled out with mation and was signed by an unit section was filled out with comment indicated the resident tement. In the comments ated pending lab results were facility portion had no a thrill, or signs of infection ditional comments was written This section was signed by the  form was marked as "Hospital"  rior to dialysis portion had no and was signed by QMA 6. The a was complete. The upon rtion additional comments were was signed by the Unit t no time was indicated.  rd review began on 08/04/22 at as included end stage renal			DEFICIENCY)		
	Resident 6 had phys to dialysis care incl	sician's orders directly related					
	an order to monitor resident's left upper	an's orders indicated there was AV shunt site on the arm every shift for bruit and lood pressure in the left arm, no					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155219	A. BUILDING B. WING	00 00	COMPLETED 08/05/2022
	ROVIDER OR SUPPLIER		52654 I	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	a week on Monday, observe the AV shu infection,	arm, hemodialysis three times Wednesday, and Friday, nt every shift for signs of  If communication report for If the following:			
	code status, diet info site prior to leaving signature. Across th through with a com dialysis unit section return from dialysis	rior to dialysis portion had ormation, condition of access dialysis filled in, but no e section was a line marked ment no report received. The was complete. The upon additional comments was time, and it was signed by the			
	covid information a dialysis unit portion return to facility por	ior to dialysis portion had no nd was signed by QMA 6. The was complete. The upon tion additional comments were was signed by the Unit			
	covid information andialysis unit portion return to facility por blank. The section with Manager. The form	ior to dialysis portion had no nd was signed by QMA 6. The was complete. The upon tion additional comments were was signed by the Unit was dated for a Tuesday, not ordered dialysis days.			
	covid information and dialysis unit portion return to facility por	ior to dialysis portion had no nd was signed by an RN. The was complete. The upon tion additional comments were was signed by the Unit			

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f ´		r '	CONSTRUCTION	i i	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155219	A. BUILDING B. WING	00	COMPI	LETED /2022
		100218	<u> </u>			12022
NAME OF I	PROVIDER OR SUPPLIEF	8		ET ADDRESS, CITY, STATE, 4 N IRONWOOD RD	ZIP COD	
MAJEST	IC CARE OF SOUT	TH BEND		TH BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN C		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION rior to dialysis portion had no	TAG	DEFICIEN	C11	DATE
		no allergy information, and was				
		e DNS was unable to identify				
		acility did not have a key or				
	-	ntify signatures. The dialysis				
	_	mplete. The upon return to				
		itional comments were blank.				
	_	ned by the Unit Manager. The a Thursday, not one of				
	Resident 6's ordered					
	Resident 6 5 ordered	a diarysis days.				
	Dated 7/8/22, the pr	rior to dialysis portion had no				
	covid information,	no allergy information, and was				
		The dialysis unit portion was				
		return to facility portion				
		ts were blank. The section was				
	signed by the Unit I	Manager.				
	Dated 7/11/22, the	prior to dialysis portion did not				
		rictions, new medications, labs,				
	or any signature. Th	ne dialysis unit portion had				
		mments. The upon return				
	-	other than the Unit Manager				
	initials and the date	•				
	Dated 7/12/22 the t	prior to dialysis portion was				
		rough with the comment no				
		tten. The dialysis unit portion				
	_	upon return portion additional				
		nk and signed with the Unit				
		he form was dated for a				
	<u> </u>	f Resident 6's ordered dialysis				
	days.					
	Dated 7/13/22, the 1	prior to dialysis portion had no				
		and was signed illegibly by an				
		he DNS was unable to identify				
	-	lialysis unit portion was				
		return to facility portion				
	additional comment	ts were blank. The section was				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155219	B. WI	B. WING			/2022
	PROVIDER OR SUPPLIEF			52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	signed by the Unit I	Manager.					
	covid information, information, no local signed with the Uniterturn from dialysis were blank and signinitials.  Dated 7/19/22, the provide information and dialysis unit portion return to facility poblank. The section with the s	prior to dialysis portion had no no mental status, no allergy ation of access site, and was it Manager initials. The upon a section additional comments ned with the Unit Manager  prior to dialysis portion had no and was signed by QMA 6. The in was complete. The upon rition additional comments were was signed by the Unit the form was dated for a					
	Tuesday, not one of days.  Dated 7/20/22, the provide information a	f Resident 6's ordered dialysis  prior to dialysis portion had no and was signed by QMA 6. The a was complete. The upon					
	return to facility po	rtion additional comments were was signed by the Unit					
	covid information a dialysis unit portion return to facility po blank. The section v Manager. The form one of Resident 6's	prior to dialysis portion had no and was signed by QMA 6. The n was complete. The upon rtion additional comments were was signed by the Unit was dated for a Tuesday, not ordered dialysis days.					
	covid information a dialysis unit portior comments. The upo	prior to dialysis portion had no and was signed by an LPN. The had blank additional on return to facility portion to were blank. The section was					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/05/2022
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	D BE COMPLETION
	code status, diet inf medication, medication, medication present, thrill preser portion was not signt through the section the line no report reportion was complete additional comment of the Unit Manager.  Dated 7/26/22, the provide information and dialysis unit portion see new orders. The additional comment signed by the Unit I for a Tuesday, not of dialysis days.  There were 2 forms to dialysis treatment signature. The dialy upon return from dialysis treatment signature. The dialy upon return from dialysis of the Unit I time. 2: had the price line through and the received. In that are medications, labs, a and signs of infection on signature. The dialymanager.  There were 2 forms of the time of the time of the time of the time of the time. The dialymanager.	prior to dialysis portion had no and was signed by an LPN. The in had additional comments to expon return to facility portion its were blank. The section was Manager. The form was dated one of Resident 6's ordered  I dated 7/27/22. 1: had the prior it filled out with an LPN was portion was empty and the alysis was signed with the Manager with a date but no our to treatment section with a excomment written no report it addet, compliance, access site location, bruit, thrill, on were completed. There was italysis unit portion was in to facility portion had no its, was signed by the Unit			
	signature. The dialy	t filled out with an LPN sis portion was empty and the alysis was signed with the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/05/2022			LETED		
	PROVIDER OR SUPPLIER		52	2654 N	DDRESS, CITY, STATE, ZIP COD I IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	II. PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	LISC IDENTIFYING INFORMATION	TA		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	initials of the Unit I treatment section w comment written not diet, compliance, m location, bruit, thril completed. There w unit portion was corportion had no addiby the Unit Manage Tuesday, not one of days.  Dated 7/29/22, the p completed and sign unit portion was corportion additional c portion was signed  Dated 8/1/22, the provide information and dialysis unit portion return to facility portion to facility portion through it with received. It had diet medical problems, I portion did not have portion was completed Unit Manager. Truesday, not one of days.	Manager. 2: had the prior to ith a line through and a preport received. In that area edications, labs, access site I, and signs of infection were ras no signature. The dialysis implete. The return to facility tional comments, was signed ear. The form was dated for a resident 6's ordered dialysis implete. The upon return omments were blank. The by the Unit Manager.  The form was dated for a resident of the upon return omments were blank. The by the Unit Manager.  The upon return omders were was signed by QMA 6. The upon retion additional comments were was signed by the Unit I was complete. The upon retion additional comments were was signed by the Unit I was complete. The upon retion additional comments were was signed by the Unit I was complete. The upon retion additional comments were was signed by the Unit I was complete. The dialysis te. The section was signed by the form was dated for a resident 6's ordered dialysis reior to dialysis portion had no	TA	.G	DEFICIENCY)		DATE
	covid information a dialysis unit portior return to facility po	nd was signed by an LPN. The was complete. The upon rtion additional comments were was signed by the Unit					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
ANDILAN	or conduction	155219	B. WII		<u></u>	08/05/2022	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF SOUTH BEND		<u> </u>	52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Ι	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	Manager.						
	(Patient Care Tech) forms with the lines dialysis nurse.  During an interview indicated she markethere the paper was not accompany the rRN 7 was able to she charting the sheets sinformation on them not requested or app for the nursing hom company had people.  A policy provided bittled, "Qualified M job description for C description did not in the policy provided bittled, "Dialysis Carindicated Conting resident's condition complications befor Assessment of the after dialysis facility's playereturn paperwork with the policy provided by t	n. RN 7 indicated the DNS had broached her about education e staff. She indicated her e available to do the training.  By DNS on 8/5/22 at 10:44 AM edication Aide (QMA)" was a QMA. It indicated job include doing assessments.  By DNS on 8/5/22 at 10:44AM re" last revision date July 2020, used assessment of the					
F 0755 SS=D	483.45(a)(b)(1)-(3 Pharmacy	)					
Bldg. 00	,	/Pharmacist/Records					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155219	B. W	NG		08/05/	/2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	₹			N IRONWOOD RD		
MA IEST	IC CARE OF SOUT	TH REND			I BEND, IN 46635		
IVIAJEST		TI DEND		300111			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.45 Pharmac						
		provide routine and					
		and biologicals to its					
		in them under an agreement					
		3.70(g). The facility may					
		personnel to administer					
	_	permits, but only under the					
	general supervision	on of a licensed nurse.					
	§483.45(a) Proce	dures. A facility must					
	- , ,	eutical services (including					
	procedures that a	ssure the accurate					
	acquiring, receivir	ng, dispensing, and					
	administering of a	ll drugs and biologicals) to					
	meet the needs of	f each resident.					
	\$400 45(b) Camila	o Compulsation. The facility					
	- , ,	e Consultation. The facility					
		btain the services of a					
	licensed pharmac	ist wild-					
	§483.45(b)(1) Pro	vides consultation on all					
	- , , , ,	ovision of pharmacy services					
	in the facility.						
		ablishes a system of					
		and disposition of all					
	controlled drugs in	n sufficient detail to enable					
	an accurate recor	nciliation; and					
	8483 45(b)(3) Det	termines that drug records					
	- , , , ,	hat an account of all					
	controlled drugs is						
	periodically recon						
		on, interview, and record	F 02	755			08/26/2022
		failed to ensure adequate			F 755		00,20,2022
		lates on medications for 2 of 3			Labeling of Drugs and		
		s Affected 11 of 59 residents			Biologicals		
		nt 47, Resident 4, Resident 49,			1. What corrective action(s	s)	
	· ·	ent 7, Resident 45, Resident 44,			will be accomplished for those	-	
		ent 50, Resident 114, and			residents found to have beer		

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G 00	COMPLETED	
		155219	B. WING		08/05/2022	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP COD		
				54 N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	TH BEND	SOL	JTH BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDENCE NAVIOE CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	DE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DATE	
	Resident 300)			affected by the deficient		
				practice;		
	Findings include:			a. Medication/ Insulin fou	nd to	
	i mamga merade.			be out of compliance with		
	1) In an observation	n on 8/2/22 at 9:09 AM, LPN 2		labelling/ dating policy were		
	1 '	ving medications were not				
	labeled properly:	ving medications were not		discarded immediately upor	'	
	labeled property:			finding.		
	D 11 4471 E1	1.1 1.4 1		b. Education of all nursing	~	
		se had no open date. A record e Flonase was ordered on		on drug expiration dating po	-	
		e Flonase was ordered on		and policy placed in the from	זו זו	
	6/10/22.			each Narcotic book on the		
				medication cart for quick		
	_	pened Flonase nasal inhalers		reference.		
	_	te. Flonase was ordered on				
	4/25/22.			2. How other residents		
				having the potential to be		
		opened container of MiraLAX.		affected by the same defic		
		not labeled with an opened		practice will be identified a	and	
	date. The MiraLAX	X was ordered on 6/23/22.		what corrective action(s) v	vill	
				be taken;		
	Resident 48 had a b	oottle of opened MiraLAX		a. All residents have the		
	without an opened	date. The MiraLAX was		potential to be affected by the	he	
	ordered on 6/16/22.			deficient practice. The nursi	ing	
				management team audited	all	
	On this cart there w	vas a bottle of opened Tylenol		medication carts to ensure	all	
	liquid. It did not ha	ve an opened date. The		opened medications were d	ated	
	pharmacy label was	s unable to be read with		and labeled per policy and		
	accuracy to identify	to whom it belonged.		medications to be considered	ed out	
		· ·		of compliance were immedi		
	During an interview	v on 8/2/22 at 9:09 AM, LPN 2		discarded per facility policy.	-	
	1	ware medications should be				
		n date when staff first opened		3. What measures will b	e put	
	them.	эрэмээ		into place and what syster		
				changes will be made to		
	2) In an observation	n on 8/2/22 at 9:24AM, QMA		ensure that the deficient		
		ne following medications		practice does not recur;		
	without proper labe			<b>I</b> −	aont	
	without proper labe	mig.		a. The nursing managen		
	Danislansk 7.1 1			team will audit medication of		
	Resident / had an o	pened bottle of MiraLAX		on a weekly basis for 4 wee	eks,	

without an opened date. The MiraLAX was

then monthly for 6 months, and

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155219	B. WING		08/05/2022
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
				N IRONWOOD RD	
MAJEST	IC CARE OF SOUT	TH BEND	SOUTH	1 BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	ordered on 3/8/22.			quarterly thereafter.	
	ordered on 37 0722.			quarterly triorcattor.	
	Resident 45 had an	opened bottle of insulin		4. How the corrective	
		ave an opened date. Lispro was		action(s) will be monitored to	
	ordered on 7/13/22.			ensure the deficient practice	
	ordered on 7/13/22.			will not recur, i.e., what quali	
	Pasident 11 had an	opened bottle of liquid		assurance program will be p	-
		opened date. Tylenol was			ut
	ordered on 5/30/22.			into place;	4
	ordered on 3/30/22.	•		a. The nursing manageme	
	D: 1 4 0 1 - 1 2			team will utilize the Qapi audit	
Resident 40 had 2 medications without opened				medication storage review for	
dates. A bottle of valproic acid (Depakote)				weekly, monthly, and quarterly	
ordered on 4/18/22 and a bottle of Silace				medication carts audits. If 100	
	(docusate sodium)	ordered on 5/19/22.		compliance is not obtained, ar	
	D 11 . 501 1 1			action plan will be developed	
		pottle of liquid docusate		reviewed by the monthly Qapi	
		ned without an opened date.		committee.	
	Docusate sodium w	vas ordered on 3/15/22.			
				5. Who is the "Team" that	
		n opened bottle of insulin		will review and audit? Who	
	_	pened date. Lispro was		will oversee that the "Team"	is
	ordered on 7/21/22.	•		conducting the audits and	
				reviews as pledged?	
		n opened bottle of MiraLAX in		a. All reviews and audits w	
		ned date. The MiraLAX was		completed by the IDT team. T	
		with a discontinued date of		ED/ DNS followed by the MDS	5,
		00 no longer resided in the		SSD, Therapy Director, and U	Init
	facility.			Manager will ensure that all a	udits
				and reviews are completed	
		v on 8/2/22 at 9:24AM, QMA 3		accurately and promptly.	
		rained on ensuring open dates			
	_	when opened and on check for		6. By what date the system	nic
	expiration dates. Ql	MA 3 was not able to indicate		changes for each deficiency	
	how long after bein	g opened, medications were		will be completed.	
	allowed to be used.			a. 8/26/2022	
	The DNS (Director	of Nursing Services) provided			
		lure on 8/2/22 at 3:53 PM. The	1		
		ministering Medications"			
		e expiration/beyond use date on			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER  155219	UILDING	00	COMPL 08/05/	ETED
	PROVIDER OR SUPPLIER		52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	container, the date of container.  The policy labeled; indicated4. Drug	"Storage of Medications" containers that have missing er, or incorrect labels are				
F 0758 SS=D Bldg. 00	Use §483.45(e) Psychology §483.45(c)(3) A pso- drug that affects b with mental proces	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any rain activities associated sses and behavior. These are not limited to, drugs in gories:				
	resident, the facilit §483.45(e)(1) Res psychotropic drugs unless the medica specific condition a documented in the §483.45(e)(2) Res psychotropic drugs	e clinical record; sidents who use s receive gradual dose				
		ehavioral interventions, ontraindicated, in an effort				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155219 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review the facility F 0758 F 758 08/26/2022 failed to ensure side effect monitoring for 1 of 5 Free from Unnecessary residents receiving psychotropic medications. Psychotropic Meds/PRN Use (Resident 59) What corrective action(s) will be accomplished for those Findings include: residents found to have been affected by the deficient Resident 59's record review began on 08/03/22 at practice; 11:11 AM. Diagnoses included; major depressive Education of all nursing staff disorder, anxiety, and insomnia. Resident 59's on the side effect monitoring of all current MDS (minimal data set assessment) dated psychotropic medications and 7/13/22 indicated Resident 59 had minimal other monitor-required cognitive impairment. Resident 59's behaviors medications.

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were assessed with none occurring per MDS

MDS indicated he took antidepressants and

antianxiety medications.

section E. Section N related to medications on the

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and sedatives completed.

Full facility audit of residents

on anti-depressants, anti-anxiety,

anti-convulsive, diuretics, opioids,

anti-psychotic, anti-coagulant,

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CPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDIC	AID SERVICES		O					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA7					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COM					

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219			COMP	(X3) DATE SURVEY COMPLETED 08/05/2022	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	TION LD BE	(X5) COMPLETION	
	`			CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE		
TAG	Resident 59 had an medications: Reme disorder, Zoloft 100 disorder, Zoloft 500 disorder, and clona disorder. Resident is monitor for side effect the psychotropic market behaviors were being the focus of behavior intervention to notion behaviors.  Resident 59's care predications with the medications with the medications in medications with the medications in medications.	ting under tasks, indicated no	TAG	2. How other residents having the potential to be affected by the same depractice will be identified what corrective action(see taken;  a. All residents have the potential to be affected by deficient practice. IDT team audited all residents on psychotropic medications other monitor-required medical to ensure monitoring of all effects and PRN use.  3. What measures will into place and what systems changes will be made to ensure that the deficient.	s pe ficient d and e) will he y the am sand edications II side	DATE	
	medication include adverse reactions a involuntary movem In an interview on (Social Services Di had no behaviors as specific monitoring	e focus of psychotropic d observing for specific and to administer an ment test every 6 months.  08/03/22 at 1:49 PM, the SSD rector) indicated Resident 59 and therefore there was no g being done. The SSD was why Resident 59 was not exide effects.		practice does not recur; a. IDT team completed audit of all residents on medications that require monitoring to ensure propare in place for monitoring side effects. IDT team will residents on psychotropic medications on admission thereafter.	d an per orders g of all ll audit		
	Regional Nurse Co should have been n psychotropic medic A policy titled "Me Prescribing-Clinica	8/4/22 at 11:16AM, the nsultant indicated Resident 59 nonitored for side effects of eations.  dication Utilization and al Protocol" provided by nsultant on 8/4/22 at 9:46AM		4. How the corrective action(s) will be monitor ensure the deficient prawill not recur, i.e., what assurance program will into place; a. IDT team will audit on psychotropic medication other monitor-required medication.	ctice quality be put residents ons and		

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	OF CORRECTION	IDENTIFICATION NUMBER  155219	A. BUILDING B. WING	00	COMPLETED 08/05/2022
	ROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	frequency, intensity Identification2. The evaluate the effective esidet regimenTreat The staff and physic	inptoms should be ficient detail (onsetm, duration, location, etcCause he physcian and staff will reness of the medcations in a atment and Management4. It will identify and address ded, undesirable		on admission and quarterly thereafter.  5. Who is the "Team" that will review and audit? Who will oversee that the "Team' conducting the audits and reviews as pledged?  a. All reviews and audits we completed by the IDT team. Ted. DNS followed by the MD SSD, Therapy Director, and to Manager will ensure that all a and reviews are completed accurately and promptly.  6. By what date the system changes for each deficiency will be completed.  a. 8/26/2022	' is vill be The S, Unit udits
F 0838 SS=E Bldg. 00	facility-wide assess resources are neck residents competed operations and emmust review and unecessary, and at must also review assessment when plans for, any chair substantial modifice.	assessment. conduct and document a sment to determine what essary to care for its ently during both day-to-day nergencies. The facility pdate that assessment, as least annually. The facility and update this ever there is, or the facility enge that would require a sation to any part of this facility assessment must			

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	OF HEALTH AND HU MEDICARE & MEDIC						RM APPROVED (B NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/05/2022	
	PROVIDER OR SUPPLIE			52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	(i) Both the numb facility's resident (ii) The care requipopulation considered conditions, physical activities and food (i) All buildings ar structures and verifications (iii) Services provide and verapped (iii) Services provided (iiii) Services provided (iiiiiiiii) Services provided (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ired by the resident lering the types of diseases, cal and cognitive disabilities, d other pertinent facts that in that population; petencies that are vide the level and types of the resident population; environment, equipment, er physical plant at are necessary to care for and Itural, or religious factors Illy affect the care provided luding, but not limited to, d and nutrition services.  er facility's resources, limited to, and/or other physical						

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emergencies; and

(both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;

understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and

(vi) Health information technology resources, such as systems for electronically managing

(v) Contracts, memorandums of

Event ID:

1P7M11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU			COMPI	
		155219	B. W	ING		08/05	/2022
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	TH BEND		SOUTH	H BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		d electronically sharing					
	Iniornation with o	ther organizations.					
	§483.70(e)(3) A fa	acility-based and					
		risk assessment, utilizing					
	an all-hazards app						
		on, interview, and record	F 08	338			08/26/2022
		ailed to ensure a complete and			F 838		
		essment for the time period of					
	8/2021 through 7/20	022.			Facility Assessment		
	Findings include:				1 What corrective action/	e)	
	rmanigs include:				1. What corrective action(s will be accomplished for tho	-	
	During an observati	ion on 08/01/22 at 09:18 AM,			residents found to have been		
	_	Hall doors were locked with a			affected by the deficient	•	
		aff could be observed on the			practice;		
		doors with resident names.			a. IDT team reviewed and		
	One staff person wa	as assigned to the unit. One			updated the facility assessme	nt to	
		hospital, one resident was at			include every room in the facil	lity.	
		er 2 residents were in their					
		tified Nurse Aide) was the only			2. How other residents		
		ved on the secured unit from			having the potential to be		
	9:18 AM to 10:03 A	AIVI.			affected by the same deficie		
	In an interview on (	08/01/22 at 10:03 AM, the ED			practice will be identified and		
		r) indicated the agency nurse			what corrective action(s) will be taken;	1	
	*	ore the DNS (Director of			a. All residents have the		
		vas to be monitoring the unit.			potential to be affected by the		
		ne facility had lower acuity			deficient practice. Full facility		
		n the unit. The ED indicated			of all resident rooms to be		
	-	were one person assist were			included in the facility		
		t. The ED indicated Human			assessment.		
		he unit behind another set of					
		ould render assistance, but had			3. What measures will be p		
	no clinical knowled	ge.			into place and what systemic	С	
	In an inter	0/1/22 at 10:14 AM 41 DNG			changes will be made to		
		3/1/22 at 10:14 AM, the DNS y opened the unit on Friday			ensure that the deficient		
		ndicated nursing was to do			practice does not recur; a. IDT team will review and	4	
		every 2 hours. She indicated			undate facility assessment on		

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155219 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the facility would try to keep a QMA (Qualified quarterly basis. Medication Aide) on the unit. The DNS indicated staff could use the overhead system for an How the corrective emergency and all staff had her cell phone action(s) will be monitored to number. ensure the deficient practice will not recur, i.e., what quality During an observation on 08/02/22 at 10:18 AM, assurance program will be put QMA 5 was the only staff on the North Unit. into place; There were 3 residents on the hall. QMA 5, during IDT team will review and an interview indicated it had been the Covid unit update facility assessment on a and now the facility was turning it into a rehab to quarterly basis. home type unit. The doors were closed and locked requiring use of a key pad. There were no 5. Who is the "Team" that numbers above the pad to indicate the code. will review and audit? Who will oversee that the "Team" is During an observation and interview on 8/3/22 at conducting the audits and 11:28AM one door open was open to the North reviews as pledged? All reviews and audits will be unit. The sign on the door indicated the keep the doors closed at all times. QMA 3 indicated she completed by the IDT team. The normally worked evenings and was alone on the ED/ DNS followed by the MDS, unit for long periods of time. QMA 3 indicated SSD, Therapy Director, and Unit during the day it was busier with appointments, Manager will ensure that all audits management, visitors, and dialysis. and reviews are completed accurately and promptly. A review of the facility assessment dated 8/2021, provided by the ED on 8/1/22 entrance indicated By what date the systemic the facility would schedule staffing for only one changes for each deficiency unit. There was no indication or assessment for 2 will be completed. units. The facility assessment indicated the 8/26/2022 facility would have a maximum census of 60. On 8/1/22 the census was reported as 62. On 8/4/22 at 4:48 PM, the ED provided a 14 day account of the daily census on the North Unit. The rooms had the following number of people on the following days:

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7/17/22-7/19/22 6 residents 7/20/22-7/26/22 7 residents 7/27/22 9 residents 7/28/22 3 residents

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If continuation sheet

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155219	B. W	ING		08/05/	2022
	ROVIDER OR SUPPLIER		<u> </u>	52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIE		ID			(X5)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
F 0842 SS=E Bldg. 00	REGULATORY OR 7/29/22-7/31/22 4 ro 8/1/22-8/4/22 3 resident A total of 11 resident 14 day period.  No policy and proce assessment was proved 483.20(f)(5), 483.7 Resident Records §483.20(f)(5) Resident Facility may not be resident-identified (ii) The facility may resident-identified accordance with a agent agrees not total information except itself is permitted total \$483.70(i) Medical §483.70(i) Medical §483.70(i) (1) In accordance with a gent agrees not total information except itself is permitted total information except itself is permitted total \$483.70(i) Medical §483.70(i) Medical §483.70(i) (2) The confidential all information except (iii) Readily access (iv) Systematically §483.70(i)(2) The confidential all information except (i) To the individual resident's records, except (i) To the individual records (iii) To the individual records (iiii) To the individual records (iiii) To the individual records (iiii) To the individual records (iiiii) To the individual records (iiii) To the individual records (iiiii) To the individual records (iiiiiii) To the individual records (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	dents ats resided on North unit in the  edure regarding facility vided prior to or during exit.  70(i)(1)-(5)  - Identifiable Information dent-identifiable information. ot release information that able to the public. y release information that is le to an agent only in contract under which the o use or disclose the to the extent the facility to do so.  I records. coordance with accepted lards and practices, the ain medical records on are- umented; sible; and organized  facility must keep ormation contained in the form or storage method of ot when release is- al, or their resident		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
	•	ere permitted by applicable					
	law;						
	(ii) Required by La	w; payment, or health care					
	(m) i oi ii ealinent,	payment, or nealth call	1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00 B. WING		COMPL	(X3) DATE SURVEY COMPLETED 08/05/2022	
	ROVIDER OR SUPPLIE			52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	1	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	operations, as per compliance with 4 (iv) For public hear abuse, neglect, or oversight activities proceedings, law organ donation proof to coroners, medirectors, and to a health or safety as compliance with 4 §483.70(i)(3) The medical record introduced destruction, or un §483.70(i)(4) Medical record introduced for- (i) The period of tili) Five years from when there is no in (iii) For a minor, 3 reaches legal age §483.70(i)(5) The contain- (i) Sufficient information in the comprehension of the complete services provided (iv) The results of screening and resident; (ii) A record of the contain- (iii) The comprehension of the complete services provided (iv) The results of screening and resident; (ii) A record of the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete services provided (iv) The results of screening and resident in the complete servic	rmitted by and in 15 CFR 164.506; alth activities, reporting of a domestic violence, health is, judicial and administrative enforcement purposes, urposes, research purposes, redical examiners, funeral avert a serious threat to is permitted by and in 15 CFR 164.512.  If acility must safeguard formation against loss, authorized use.  Itical records must be in the date of discharge requirement in State law; or in the date of discharge requirement in State law; or in years after a resident in under State law.  In medical record must in the interior in the date of discharge requirement in State law; or in years after a resident in under State law.  In medical record must in the interior in the date of discharge requirement in State law; or in years after a resident in the interior in the determinant in the interior in the determinant in the interior in the determinant in the interior in the date of discharge requirement in State law; or in the date of disch					
		on and record review the	F 08	42	E 942		08/26/2022
	l actiff tailed to acc	curately document assessments	1		F 842		ĺ

PRINTED: 09/08/2022

	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/05/2022
NAME OF	PROVIDER OR SUPPLIEF	<b>.</b>		ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD	
MAJES	TIC CARE OF SOUT	H BEND		H BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, and the second	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
		ecords reviewed. (Resident		Resident Records	
	Findings include:  1. In nn observation facility MD (Medic performing an initia MD put on gowns a left heel wound. Or the MD commented Resident 112's heel put the foot back do the DNS (Director come in and reapply to Resident 112's luthe facility would a they were unable, h antibiotics. The MI	an on 8/2/22 at 1:30 PM, the all Doctor) was observed all visit for Resident 112. The and gloves then unwrapped a acce the wound was unwrapped, at the wound was not on but on his ankle. The MD then own on a towel. He explained of Nursing Services) would by a dressing. The MD listened angs and heart. He indicated attempt to get IV access but if the would order an oral but did not bring dressing or any measuring device with		1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice; a. IDT team reviewed and audited all residents wound assessments to ensure accurate documentation. b. IDT completed an audit of residents' code status. c. Education of all nursing on admission wound assessments.  2. How other residents having the potential to be affected by the same deficients.	se n ate of all staff
	indicated the MD h calf had a 3cm openote was dated 8/2/NP (Nurse Practition the wound had been length x 4.12cm with assessment dated 7/wound was unstage 5.2cm.  2. Resident 112's ac 7/26/22 at 4:05 AM Nursing Services).	M, Resident 112's record review ad documented the left lower n ulcer with clean margins. The 22 at 1:38PM. A note from the oner) on 8/3/22 at 3:32 indicated n measured and was 7.11cm dth x 0.3cm depth. A wound /27/22 at 3:14 PM indicated the table and measured 7.4cm x dmission assessment was dated I, by the DNS (Director of The assessment was signed the DNS. Resident 112's		practice will be identified and what corrective action(s) will be taken; a. All residents have the potential to be affected by the deficient practice. Full facility a of all residents wound assessments and code status  3. What measures will be printo place and what systemic changes will be made to ensure that the deficient practice does not recur; a. The IDT team will review audit wound assessments dail and after admission on the ne	d I audit c v and ly

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paperwork.

admission to the facility was documented as

7/26/22 at 4:12 PM on the hospital discharge

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business day.

If continuation sheet

How the corrective

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLETED			
		155219	B. W	'ING		08/05/2022	
				CEDEET	A DODDEGG CHTM CTATE THE COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	10 0 A DE 0E 00 LIT	TH DEND			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H REND		SOUTH	H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					action(s) will be monitored to	0	
	3. A review of dialy	ysis paperwork started on			ensure the deficient practice		
	· ·	Γhe following was noted.			will not recur, i.e., what quali		
					assurance program will be p	-	
	a. Resident 2, dated 7/10/22, the top section of the dialysis communication was filled out code status,				into place;		
					a. IDT team will review and	, l	
		restrictions, medication			audit wound assessments dai		
		roblems since last dialysis, labs			and after admission on the ne	•	
	drawn, access site assessment bruit, thrill, and				business day.	Λι	
	signs of infection. At the top of the section was a				business day.		
	line drawn through with the comment error no				5. Who is the "Team" that		
	report received. The dialysis unit portion was				will review and audit? Who		
	completed. The post dialysis portion was signed				will oversee that the "Team"	io	
	with initials by the Unit Manager. No time of				conducting the audits and	15	
	return assessment w	_			_		
	Teturii assessificiti v	vas marcatea.			reviews as pledged?	وط النو	
	h Dagidant 6 datad	17/25/22, the predialysis			a. All reviews and audits w		
		sident name, date, code status,		completed by the IDT team. The			
		ompliance, medication, medical			ED/ DNS followed by the MDS		
		-			SSD, Therapy Director, and U		
	1 ~	vn, bruit present, thrill present,			Manager will ensure that all a	uaits	
	_	on. This portion was not			and reviews are completed		
	_	a line going through the			accurately and promptly.		
		ment written above the line.				·	
		ated no was report received.			6. By what date the system		
		ortion was complete. The upon			changes for each deficiency		
		ional comments was blank,			will be completed.		
		of theUnit Manager, a date but			a. 8/26/2022.		
	no time.						
	TEIL	1 . 17/27/22 1 1 1 1					
		ms dated 7/27/22. 1: had the					
	, ·	atment filled out with an LPN					
	, ,	ysis portion was empty and the					
	1 -	alysis was signed with the					
		Manager. The form was dated,					
		had the prior to treatment					
		through with the comment no					
	1 -	that area diet, compliance,					
	medications, labs, a	access site location, bruit, thrill,					
	and signs of infection	on were completed. There was					
	no signature. The d	ialysis unit portion was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	A. BU	A. BUILDING <u>00</u> COM		COMPI	) DATE SURVEY COMPLETED 08/05/2022	
	PROVIDER OR SUPPLIER			52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DEOVIDEDIC DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
	complete. The retur	n to facility portion had no						
	additional comments, and was signed by the Unit							
	Manager.							
	There were two for prior to dialysis tree signature. The dialy upon return from di the of the Unit Man treatment section we comment no report compliance, medical location, bruit, thril completed. There we unit portion was comportion had no addi by the Unit Manage	ms dated 7/28/22. 1: had the atment filled out with an LPN rais portion was empty and the alysis was signed with initials rager. 2: had the prior to ith a line through and the received. In that area diet, ations, labs, access site l, and signs of infection were ras no signature. The dialysis emplete. The return to facility tional comments, was signed ear. The form was dated for a f Resident 6's ordered dialysis						
	line through it with received. It had diet medical problems, portion did not have dialysis portion was signed by the Unit for a Tuesday, not of dialysis days.  c. Resident 7, 7/10/out code status, memedication changes dialysis, labs drawn thrill, and signs of i section was a line document error nor unit portion was con	trior to dialysis portion had a the comment no report t, compliance, medication, tabs, bruit, and thrill. The e a nurse signature. The s complete. The section was Manager. The form was dated one of Resident 6's ordered  22 The top section was filled that status, fluid restrictions, to, medical problems since last to, access site assessment bruit, infection. At the top of the rawn through with the eport received. The dialysis impleted. The following to signed with initials by the						

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219			X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETED  B. WING 08/05/2022		
	PROVIDER OR SUPPLIE		5265	ET ADDRESS, CITY, STATE, ZIP COD 54 N IRONWOOD RD JTH BEND, IN 46635	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
F 0867 SS=E Bldg. 00	During an interview (Patient Care Tech indicated the comm report received" was During an interview (Registered Nurse indicated she mark the dialysis report processed computerized chart labeled Resident 2, The documents which post assessment information of the performed and resident document prior to the performed and resident document and computerized chart labeled Resident 2, The documents which indicated the prior be performed and resident document prior to the performed and resident document and computerized documents. The processed in the prior performed and resident documents. The processed in the prior processed in the prior performed and resident documents. The processed in the prior performed and resident documents. The processed in the prior performed and resident documents. The processed in the prior performed and resident documents. The processed in the prior performed and resident documents. The processed in the prior performed and resident documents. The processed in the prior performed and performed in the prior performed in the perform	5/22 at 9:16 AM, the DNS to dialysis assessment was to ecorded on the assessment the resident leaving for dialysis.  dure was provided regarding ation prior to exit.  vement Activities by assessment and	TAG	DEFICIENCY	DATE
	review the facility	on, interview and record failed to ensure compliance was g prior identified concerns.	F 0867	F 867  QAPI/QAA Improvement Activities	08/26/2022

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1P7M11 Facility ID: 000124

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· '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/05/2022	
		100210	Б. ,,		- DDDDDDD OWN OF THE STREET	00/00/	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD		
MAJESTIC CARE OF SOUTH BEND					H BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This affected 14 residents residing in the facility.				1. What corrective action(		
		iled to ensure complete records			will be accomplished for the		
		e meetings and compliance for			residents found to have bee	n	
		iewed (August 2021, September			affected by the deficient		
		1, November 2021, December			practice;		
	2021, January 2022	2, and February 2022.			a. Education of all nursing	staff	
					on both pre and post		
	Findings include:				assessments of all dialysis		
					residents		
		survey completed on 7/2/2021			b. Full facility audit of all		
	-	bliance in the areas including			residents on dialysis were		
		ation storage. During the			completed and all dialysis		
	annual survey there	_			assessments are completed t	-	
	noncompliance concerning dialysis, and			Point-Click-Care (PCC) program.			
	medication storage.				c. Medication found to be	out	
					of compliance with labelling/		
		vation on 8/2/22 at 9:00AM in a			dating policy were discarded		
		tion carts 2 of 3 had			immediately upon finding.		
		at opened dates. These			d. Education of all nursing		
	_	rescribed to 11 different			on drug expiration dating poli	-	
		ne residents no longer resided			and policy placed in the front	if	
	in the facility. See I	F 755.			each Narcotic book on the		
	2) D	00/04/22 + 02 +0 73 5			medication cart for quick refer	rence	
		iew on 08/04/22 at 02:40 PM,					
		d she had an issue in dialysis			2. How other residents		
	_	f the machine early due to low			having the potential to be	4	
	_	sident 7 did not recall being			affected by the same deficie		
	assessed immediate	ely upon returning to the unit.			practice will be identified an		
		0/5/00 + 1 50 DM DM 7			what corrective action(s) will	ll	
		8/5/22 at 1:52 PM, RN 7 was			be taken;		
		cident and showed their			a. All residents have the		
		he incident including making			potential to be affected by the		
	the nursing home st	iaii aware.			deficient practice. IDT team		
	In an inter	0/5/22 at 11.21 AM 4L - DNG			completed an audit of all dialy		
		8/5/22 at 11:21AM, the DNS			residents to ensure that pre a	na	
	maicated sne was n	ot aware of the incident.			post assessments were		
	A manage 4	A modidanta naii 3: 1 :			completed. The nursing	,	
		4 residents receiving dialysis,			management team audited al		
	-	11:51AM. The review indicated			medication carts to ensure all		
incomplete communication from the facility to the		ı		opened medications were dat	ed		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155219		A. BUILDING 00  B. WING		COMPLETED 08/05/2022	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF SOUTH BEND			52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE		
	dialysis centers. The incomplete and required locate. See F698.  3) During an intervioral Executive Director to provide any QAF his becoming the Educumented April 2 ED was able to show identified concerns addressed with the education of the Edu	e communication books were uired multiple requests to  ew on 8/5/22 at 11:51, the (ED) indicated he was unable PI meeting information prior to D. His first QAPI meeting was 2022, covering March 2022. The w a spread sheet with and when they would be QAPI team of managers for all D indicated he had read the		and labeled per policy and any medications to be considered of compliance were immediate discarded per facility policy.  3. What measures will be printo place and what systemic changes will be made to ensure that the deficient practice does not recur; a. IDT team will complete a audit of all dialysis residents routinely. IDT team will use Post for all dialysis assessments. The nursing management team with audit medication carts on a weekly basis for 4 weeks, then monthly for 6 months, and quarterly thereafter  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; a. Weekly Qapi for the first weeks, then monthly for 6 m	y out ely  but c  c  an  CC The III  n  d  anths, 10%  n  and	
				reviews as pledged?	ill he	

PRINTED: 09/08/2022

	OF HEALTH AND HU!						RM APPROVED
	MEDICARE & MEDIC						IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		ľ	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY	
		B. W		00	COMPLETED 08/05/2022		
				_		00/00/	
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD		
MAJESTIC CARE OF SOUTH BEND					I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					completed by the IDT team. T		
					ED/ DNS followed by the MDS		
					SSD, Therapy Director, and U		
					Manager will ensure that all au and reviews are completed	idits	
					accurately and promptly.		
					accurately and promptly.		
					6. By what date the systen	nic	
					changes for each deficiency		
					will be completed.		
					a. 8/26/2022		
E 0000	400 004 11/41/01						
F 0883 SS=D	483.80(d)(1)(2)						
SS=D Bldg. 00	Influenza and Pneumococcal Immunizations						
Diug. 00	§483.80(d) Influenza and pneumococcal immunizations						
		ienza. The facility must					
	§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure						
	that-	ina procedures to ensure					
		the influenza immunization,					
	each resident or the resident's representative						
	receives education regarding the benefits and						
	potential side effects of the immunization;						
	-	is offered an influenza					
	immunization Octo	ober 1 through March 31					
	annually, unless tl	he immunization is					
	medically contrain	dicated or the resident has					
	already been imm	unized during this time					
	period;						
	(iii) The resident of						
	representative has	s the opportunity to refuse					
	immunization; and	d					

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the following:

(iv)The resident's medical record includes documentation that indicates, at a minimum,

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the

Event ID:

1P7M11

Facility ID: 000124

If continuation sheet

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DEPARTMENT	Γ OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED	
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		a. building <u>00</u>			COMPLETED	
		155219	B. W	ING		08/05/2022		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD			
MAJESTIC CARE OF SOUTH BEND				52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID	) ID SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	THE DEFICIENCY MILET BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	influenza immuniz	zation or did not receive the						
	influenza immuniz	zation due to medical						
	contraindications	or refusal.						
	8483 80(d)(3) Pp	eumococcal disease. The						
	. , , , ,	lop policies and procedures						
	to ensure that-	op policies and procedures						
		the pneumococcal						
	``	ch resident or the resident's						
	representative receives education regarding							
		ootential side effects of the						
	immunization;							
		is offered a pneumococcal						
	' '	ess the immunization is						
	medically contrair	ndicated or the resident has						
	already been imm	nunized;						
	(iii) The resident of	or the resident's						
	representative ha	s the opportunity to refuse						
	immunization; and	d						
	(iv)The resident's	medical record includes						
		at indicates, at a minimum,						
	the following:							
	(A) That the resid							
	-	s provided education						
	1	efits and potential side						
	-	ococcal immunization; and						
	' '	ent either received the						
		munization or did not						
	•	nococcal immunization due						
	i io medical contral	ndication or refusal.	F 0	223			08/26/2022	
	Based on interview	and record review, the facility	1 0	303	F 883		00/20/2022	
		oneumonia vaccines for 3 of 5			Influenza			
		for infection control. (Resident			and Pneumococcal	4		
	10, Resident 36 and				Immunizations			
	1 .,	• /			,		1	

Findings include:

1. During a record review on August 4, 2022, at

9:46 am, Resident 10's immunization status

practice;

affected by the deficient

1. What corrective action(s)

will be accomplished for those residents found to have been

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/05/2022	
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD		
MAJESTIC CARE OF SOUTH BEND				4 N IRONWOOD RD TH BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG			TAG	DEFICIENCY)	DATE	
	indicated the resident was not current with pneumonia vaccination.			a. IDT team reviewed and		
				audited all residents to ensur		
		1.17.134 1.15.2022		both consent and declination	of all	
		ed dated March 15, 2022, 10 may have pneumonia		vaccines were obtained.		
	vaccine.	To may have pheumoma		2. How other residents		
	vacenie.			having the potential to be		
	Resident 10's Minir	num Data Set (MDS)		affected by the same deficie	ent	
		pril 30, 2022, indicated the		practice will be identified an		
	resident was not cur	rrent with pneumonia		what corrective action(s) wi		
	vaccination. The M	DS assessment also indicated		be taken;		
	pneumonia vaccina	tion was not offered.		a. All residents have the		
				potential to be affected by the		
	2. Resident 36's immunization status indicated the			deficient practice. Full facility		
	resident was not cur	rrent on pneumonia		of all residents on Influenza a		
	vaccination.			Pneumococcal Immunization	S	
	A	- 1 1-4- 1 D 27, 2021		completed		
		ed dated December 27, 2021, 36 may have pneumonia		3. What measures will be	mut	
	vaccine.	on may have pheumoma		3. What measures will be into place and what system	•	
	vacenie.			changes will be made to		
	Resident 36's Minir	num Data Set (MDS)		ensure that the deficient		
		ine 23, 2022, indicated the		practice does not recur;		
	resident was not cur	rrent with pneumonia		a. The IDT team audited a	and	
		DS assessment also indicated		obtained consent and declina	ations	
	the pneumonia vacc	eination was not offered.		of Influenza and Pneumococo		
				Immunizations. IDT will obtain		
		nunization status indicated the		consents and declinations of		
		rrent on the pneumonia		residents on admission there	after.	
	vaccination.			4 How the competition		
	Δ nhysician's order	dated June 9, 2022, indicated		4. How the corrective action(s) will be monitored to	to	
	A physician's order dated June 9, 2022, indicated Resident 47 may have the pneumonia vaccine.			ensure the deficient practic		
	1 100 Idon 4/ Iliay lid	die pheamoma vaceme.		will not recur, i.e., what qua		
	Resident 47's Minir	num Data Set (MDS)		assurance program will be	-	
	assessment dated June 9, 2022, indicated the			into place;		
		rrent with pneumonia		a. IDT will obtain consents	s and	
	vaccination. The M	DS assessment also indicated		declinations of residents on		
	pneumonia vaccina	tion was not offered.		admission. Audit of all reside	nts	
				quarterly.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219  NAME OF PROVIDER OR SUPPLIER		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD		00 ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 08/05/2022		
MAJESTIC CARE OF SOUTH BEND			52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	AJESTIC CARE OF SOUTH BEND  4) ID SUMMARY STATEMENT OF DEFICIENCIE LEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  5. Who is the "Team" that will review and audit? Who will oversee that the "Team" conducting the audits and reviews as pledged? a. All reviews and audits w completed by the IDT team. T ED/ DNS followed by the MD: SSD, Therapy Director, and L Manager will ensure that all a and reviews are completed accurately and promptly.  6. By what date the syster changes for each deficiency will be completed. a. 8/26/2022	' <b>is</b> 'ill be  The S, Jnit udits	(X5) COMPLETION DATE
	pneumonia vaccine within 30 days of admission.  3.1-18(b)						

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