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| | 155322 | A. BUILDING 00<br>B. WING | 06/29/2023 |

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| MAJESTIC CARE OF WEST ALLEN | 6050 S CR 800 E 92<br>FORT WAYNE, IN 46814 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00410783, IN00411231, IN00411611 and IN00411878.<br><br>Complaint IN00410783 - Federal/State deficiencies related to the allegations are cited at F744.<br><br>Complaint IN00411231 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00411611 - Federal/State deficiencies related to the allegations are cited at F744.<br><br>Complaint IN00411878 - Federal/State deficiencies related to the allegations are cited at F744.<br><br>Survey dates: June 28 and 29, 2023<br><br>Facility number: 000215<br>Provider number: 155322<br>AIM number: 100267600<br><br>Census Bed Type:<br>SNF/NF: 82<br>Total: 82<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 77<br>Other: 3<br>Total: 82<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed July 5, 2023 | F 0000 | The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| SeAndra Robinson | RN DNS | 07/15/2023 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0744<br>SS=D<br>Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>Based on observation, interview and record review, the facility failed to ensure dementia care interventions were implemented for 3 of 4 residents reviewed (Resident K, Resident L, and Resident N).<br><br>Findings include:<br><br>1. On 6/28/23 at 1:36 P.M., Resident N's family member was interviewed. The family member indicated she had been notified there had been an incident on 6/24/23 which resulted in the resident getting a large skin tear on her forearm during care. The family member indicated the resident was never combative and was upset that such a large skin tear could occur while trying to assist her into her night clothes.<br><br>On 6/28/23 at 2:10 P.M., Resident N was observed standing in the middle of her room wearing a very large pair of blue pants. She was frowning, her brows elevated and furrowed. She indicated she had someone else's pants on, the blue ones were not hers. She sat on the bed and tried to take them off as her daughter tried to soothe her and find her a different pair of pants. After a different pair of pants were found and put on, Resident N was all smiles. She was hard of hearing and would put her ear near the speakers mouth so she could hear what was being said. She showed her daughter her left forearm where a clear dressing covered the large area and kept trying to peel the edges of the | F 0744 | What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿¿<br><br>-Resident L was discharged to another SNF for behavior management purposes. Residents K and L had resident specific care plans created to address dementia related behaviors and provide interventions for staff to implement.<br><br>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?¿<br><br>- All residents that have a dementia diagnosis with behaviors have the potential to be affected by this deficient practice.¿A facility wide audit was performed to identify all residents that had | 07/16/2023 |

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| | dressing.<br><br>On 6/28/23 at 2:49 P.M., Resident N's record was reviewed. Diagnoses included Alzheimer's disease with late onset, major depressive disorder, generalized anxiety order, and disorder of the acoustic nerve (nerve that connects from ear to brain and controls hearing and balance).<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 5/31/23, indicated the resident had severely impaired cognition. She had new mood indicators of having little interest or pleasure in doing things, feeling down or depressed, trouble falling asleep/sleeping too much, and feeling bad about herself (indicated moderate depression). She had no behaviors but had disorganized thinking. The resident required supervision and walked without assistance in her room and hallway. She required limited assistance with dressing and extensive assistance of 1 with toileting and personal hygiene.<br><br>Care plans indicated the following:<br><br>-5/3/21, the resident had cognitive impairment due to Alzheimer's disease. Interventions included to be alert to her non-verbal cues, problems or unmet needs and intervene as needed.<br>-5/3/21, exhibits signs and symptoms of anxiety with a goal of her demonstrating effective coping skills. Interventions included to listen to her needs and adjust the plan as appropriate and if combative or resistive, postpone care/activity and allow her to regain her composure and re-approach.<br>-3/1/22, the resident had behavior symptoms and physical aggression such as slapping people out of confusion with a goal of the resident's needs being met. Interventions included approaching | | been affected by the deficient practice regarding interventions for dementia related behaviors.¿Each resident affected had a resident specific care plan created to provide interventions for behaviors.<br><br>What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur?¿<br><br>-The IDT and all clinical staff will be educated on how to address dementia related behaviors, access the resident specific care plan with interventions, and how to document effectiveness of the intervention.<br><br>¿<br><br>How the corrective actions will be monitored to ensure the deficient practice will not recur¿(what¿quality assurance program will be put into place)¿<br><br>-Audit will be completed by the SSD or designee as follows daily X 4 weeks, 3X week X4 weeks, 2X week X8 weeks and 1X week X8 weeks using the dementia related behavioral interventions and care plan tool. If 100% compliance is | |

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| | her in a calm and friendly manner and explaining to her what was going to be done prior to initiating a task.<br><br>Review of behavior reports indicated Resident N had no behaviors during the month of June 2023 other than 1 episode of wandering.<br><br>A change in condition report, dated 6/24/23 at 9:50 p.m., indicated the resident had a skin tear. A new order was to keep the area covered with a dressing.<br><br>A Telehealth note, dated 6/25/23, indicated the resident had a skin tear after being combative with a CNA (Certified Nurse Aide) while being changed. Her left arm had a large skin tear and the resident kept picking at the dressing. She was completely unaware of the injury.<br><br>On 6/28/23 at 10:37 A.M., CNA 10, was interviewed. She was assigned on the hall to care for Resident N. She indicated she had never witnessed the resident be combative with anyone including staff. The resident was always happy, gave hugs and kisses, and kept to herself. CNA 10 indicated the resident did much of her own care for herself; took herself to the bathroom and dressed herself. Occasionally, she would need assistance following bowel incontinence.<br><br>On 6/29/23 at 2:02 P.M., CNA 15 was interviewed. The CNA had been caring for Resident N when she got a skin tear. The CNA indicated she hadn't been very familiar with the resident and was trying to help out the CNA assigned to that group. She asked the resident if she could help her change her pants as they were soiled and the resident said "no" however, there was stool all over her pants and on the bed linens. She thought the | | not obtained an action plan will be developed. This information will be presented monthly for the QAPI committee. | |

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| | resident had changed her mind as she stood up from the bed and started to pull down her pants. When the CNA tried to help her, the resident pushed, screamed and slapped the CNA. CNA 15 indicated she held onto the residents arm to keep her from slapping and allowed her to remove the soiled pants. When questioned, CNA 15 hadn't known the resident could be combative, how many staff were supposed to care for her, or what care was to be provided and what care the resident could perform herself. She had no care sheet, care plan, or CNA assignment sheet that explained the care to be given.<br><br>2. On 6/28/23, the following observations and interviews were completed on the secured memory care unit where Resident K resided.<br><br>-9:45 A.M., during an initial tour of the secured memory care unit, several male residents were observed ambulating throughout the hallway and other resident's rooms. An unidentified male resident, sat in a wheelchair near the door and was trying to speak with anyone that came near him. He had a grimace on his face and tears in his eyes and raised his voice at times, as he tried to communicate his frustration.In the dining room, 2 activity staff were observed trying to assist residents to sit at the table for an activity. Once seated, some of the resident's would get back up and were redirected to sit down and participate in the activity. 2 CNA's (Certified Nurse Aides) and a nurse were observed trying to provide personal care and medications to residents. They were continually up and down the hallways and into rooms trying to provide care while intervening with wandering residents going into others rooms. Resident K was seated in the dining room and participated in the balloon toss activity.<br>-11:59 A.M., residents were observed in the dining | | | |

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| | room as staff passed out lunch trays. Resident K was seated at a different table eating his lunch. Doors to the resident's rooms were closed. Staff went into each resident room, delivering trays and assisting resident's out of the rooms that were not their's. A male resident was escorted out of another resident's room. After walking a few steps down the hallway, CNA 2 observed the resident had a soiled sock and removed it from his hand.<br>-3:15 P.M., 5 residents on the memory care unit were observed wandering up and down the hallway while others sat in the dining room. 2 CNA's were seated at the nurse's station but would get up often to redirect residents away from others or intervene with resident's displaying behaviors. 1 female resident was lying on the floor near the desk. Staff were encouraging her to get off the "dirty floor". A male and female resident were overheard in the dining room, arguing and raising their voices and cursing. Staff quickly intervened and removed the female resident from the dining room. Staff present were interviewed about dementia care provided on the unit. CNA 3 indicated they always worked on the memory care unit and spent most of their time, intervening in resident conflicts or redirecting them. Most of the residents on the unit wandered, had behaviors, and would only engage in activities for very short periods of time. When questioned, CNA 3 and Nurse 5 indicated resident behaviors were documented on the computer but there were no individualized interventions to implement for resident behaviors other than distract and re-direct as the dementia of residents on the unit was so advanced. The Memory Care Unit Coordinator indicated staff tried to keep residents busy but their attention span was extremely short. When questioned about behaviors and assessment of residents prior to being placed on the unit, she indicated she'd had no involvement | | | |

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| | in who was admitted, what behaviors the residents may have and how it would affect other residents residing on the unit.<br><br>On 6/28/23 at 11:50 A.M., Resident K's record was reviewed. Diagnoses included dementia with agitation, anxiety disorder, and psychotic disorder with delusions. He resided on the secured memory care unit.<br><br>Care plans were:<br><br>-6/8/23, the resident had cognitive impairment due to dementia. The goal was for him to interact with others daily for mental stimulation with an intervention of allowing the resident extra time to respond.<br><br>-6/15/23, the resident exhibited behaviors due to dementia and anxiety. The goal was for him to seek out staff/caregiver support when feeling frustrated or provoked. Interventions were non-specific and included providing medications as ordered, if combative or resistive, postpone care/activity, re-approach, and document behaviors per behavior management program.<br><br>An admission note, dated 6/6/23 at 1:33 P.M., indicated the resident was alert and oriented to himself with clear speech. He required extensive assistance of 1 staff member to walk but his gait was unsteady. He was not easily redirected and hadn't followed verbal instructions regarding safety.<br><br>Progress notes indicated the following:<br><br>-6/7/23 at 5:46 p.m., Resident K wandered in and out of other resident's rooms, incontinent of bowel and bladder. He was uncooperative with | | | |

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| | care at times and difficult to redirect. There was no indication of behavioral interventions attempted.<br>-6/8/23 at 6:46 p.m., Resident K roamed into other resident's rooms. He walked by himself with a steady gait. He was confused to place, time, and person and was combative with care. There was no indication of behavioral interventions attempted.<br>-6/12/23 at 8:52 p.m., the resident was observed to strip naked several times while walking down the hallway and wandering into other residents rooms. He was threatening, verbally aggressive with staff and threw a dirty brief in staff's face. He was unable to be redirected or dressed. He was monitored until the behavior ended and was assisted to bed.<br>-6/13/23 at 6:54 p.m., the resident was involved in an altercation with another resident. He complained of a headache and was given Tylenol. There was no indication of behavioral interventions attempted.<br><br>A Behavior Report for June 2023, indicated Resident K had the following behaviors:<br>-1 episode of frequent crying.<br>-9 episodes of repetitive movements.<br>-9 episodes of yelling/screaming.<br>-1 episode of kicking/hitting.<br>-8 episodes of pushing.<br>-10 episodes of grabbing.<br>-4 episodes of pinching/scratching/spitting.<br>-30 episodes of wandering.<br>-19 episodes of abusive language.<br>-15 episodes of threatening behavior.<br>-5 episodes of sexually inappropriate behavior.<br>-7 episodes of rejecting care.<br><br>A counselors progress note, dated 6/27/23, indicated the resident was was no longer able to be maintained at home due to advancing | | | |

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| | dementia. Since admission, staff reported he was anxious, irritable, had sexually inappropriate behaviors towards staff and other residents, disrobed in the hallway and once threw a dirty brief at staff while being assisted to toilet. He was described as irritable, anxious, agitated, resisting care, delusional and sundowning. He had severely impaired cognition. The plan was to provide him with individual therapy and psychiatric treatment services.<br><br>3. On 6/28/23 at 12:06 P.M., Resident L's record was reviewed. Diagnoses included Schizoaffective disorder, bipolar type, major depressive disorder, anxiety disorder, psychotic disorder with delusions, and dementia with behavioral disturbance. The resident had a long psychiatric history and was hospitalized in February 2023 for physical aggression towards residents and staff which was triggered by another resident who wandered into her room.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 6/12/23, indicated the resident had moderately impaired cognition. She had several mood indicators of moderate depression and disorganized thinking. She had delusions and rejected care over 1-3 days of the assessment.<br><br>Care plans were:<br><br>-11/9/22: The resident exhibited physical aggression toward other residents. The goal was to demonstrate the ability to seek out staff when feeling frustrated or provoked. Interventions included: provide resident with personal space and place a STOP sign on the resident's door.<br><br>-3/28/22: The resident had an acute confusional episode and delusions due to schizoaffective | | | |

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| | disorder. The goal, with a target date of 7/3/23, was for the acute episode to be resolved. Interventions included: address environmental factors such as recent change in environment, environmental noise or commotion.<br><br>A psychologist progress note, dated 5/30/23, indicated the resident was visited. During the visit, the resident told the therapist she was hearing voices and seeing things that she knew were not real and wanted to go to the psychiatric hospital. She indicated she wanted out of the facility and hadn't understood why she had to stay. She believed everyone was against her and if she wasn't able to leave, she would go to "war". She refused a shot, had increased paranoia, and believed staff were trying to kill her with shots.<br><br>A Behavior Report for June 2023, indicated Resident L had the following behaviors:<br>-11 episodes of repetitive movements.<br>-24 episodes of yelling/screaming.<br>-1 episode of kicking/hitting.<br>-5 episodes of pushing.<br>-4 episodes of grabbing.<br>-14 episodes of wandering.<br>-21 episodes of abusive language.<br>-16 episodes of threatening behavior.<br>-2 episodes of sexually inappropriate behavior.<br>-6 episodes of rejecting care.<br><br>A social service note, dated 6/12/23 at 8:04 a.m., indicated the resident had increased agitation, refused her medications and was banging on the door saying she was ready to leave and go to jail. She yelled at staff and accused everyone of stealing her money. She was re-directed with snacks and a pop and agreed to take her medications. | | | |

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| | A progress note, dated 6/13/23 at 7:01 p.m., indicated the resident was involved in an altercation with another resident and was placed on 1:1 supervision until further IDT (Interdisciplinary Team) review.<br><br>An IDT note, dated 6/16/23 at 2:46 p.m., indicated a review of the resident's past 180 days of behaviors indicated a trend regarding intrusive wanderers that entered her room.<br><br>A progress note, dated 6/26/23 at 4:02 p.m., indicated the resident came out of her room, angry, because another resident had wandered into her open door and she started banging onto the door.<br><br>A progress note, dated 6/28/23 at 8:27 a.m., indicated the resident was discharged and transported to a sister facility for continued care.<br><br>On 6/28/23 at 3:20 P.M., CNA 3 and Nurse 5 were interviewed about how intrusive wandering residents were kept out of others rooms and they indicated room doors would be kept closed. When questioned, neither indicated interventions to be used if a resident hadn't wanted their door closed but wanted other residents to stay out of their room. Nurse 5 indicated it was a memory care unit and wandering residents was to be expected. She indicated use of a STOP sign or strap across the door wouldn't stop wandering residents because their dementia was too far advanced. CNA 3 and Nurse 5 indicated they would distract or re-direct to try and keep residents from wandering into others rooms. Neither CNA 3 nor Nurse 5 were aware of any specific, person centered interventions for behaviors for residents that resided on the unit. | | | |

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| | On 6/29/23 at 10:28 A.M., the Social Service Director (SSD) was interviewed. She indicated, currently, there were no specific, person-centered, dementia care plans for residents who resided on the secured memory care unit or who had a diagnosis of dementia. The facility did not have a dementia program in place but were in the process of implementing one. She indicated that she and the Memory Care Unit Coordinator were each receiving separate training from consultants on dementia care and were working on putting the "pieces together" to incorporate behaviors, dementia, and programming.<br><br>On 6/29/23 at 11:00 A.M., the SSD provided a current copy of a policy titled "Dementia Care" which stated the following: "It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being...1. The facility will assess, develop, and implement care plans through an interdisciplinary team approach that includes the resident, their family, and/or resident representative, to the extent possible. 2. The care plan goals will be achievable...3. The care plan interventions will be related to each resident's individual symptomology and rate of dementia progression...4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety...7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary...."<br><br>This Federal tag relates to Complaints IN00410783, IN00411611, and IN00411878. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155322 | A. BUILDING 00<br>B. WING | 06/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MAJESTIC CARE OF WEST ALLEN | 6050 S CR 800 E 92<br>FORT WAYNE, IN 46814 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-37 | | | |