STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00442540, IN00443587, IN00442738, and IN00441959. Complaint IN00442540 - No deficiencies related to the allegations are cited. Complaint IN00443587 - No deficiencies related to the allegations are cited Complaint IN00442738 - No deficiencies related to the allegations are cited Complaint IN00441959 - No deficiencies related to the allegations are cited Survey dates: September 30, October 1, 2, 3 & 4, 2024 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 2 Medicaid: 69 Other: 3 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bud Johnson	Executive Director	11/12/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality Review completed on 10/18/2024			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation and record review, the facility failed to provide a dependent resident an assistive device for 1 of 1 residents reviewed for accommodation of needs. (Resident 3) Finding includes: During a family interview on 9/30/2024 at 2:25 P.M., the responsible party for Resident 3 indicated he was concerned Resident 3 did not have a wheelchair to get out of bed. The family member indicated Resident 3 was always in bed when he visited and did not see a wheelchair in his room. Resident 3's family member indicated he would like him to get out of the bed. During an observation on 10/1/2024 at 9:53 A.M., 10/2/2024 at 9:45 A.M., 10/2/2024 at 2:24 P.M., 10/3/2024 at 9:09 A.M., 10/3/2024 at 11:57 A.M., and 10/4/2024 at 1:29 P.M. Resident 7 was in bed and no wheelchair was in the room. A record review was completed on 10/2/2024 at 1:37 P.M., for Resident 3. Diagnoses included, but not limited to: hemiplegia, unspecified affecting left dominant side, vascular dementia, unspecified severity, with other behavioral disturbance, and acquired absence of right leg below knee. A Quarterly Minimum Data Set (MDS) assessment, dated 9/25/2024, indicated Resident 3 had severe cognitive impairment and was dependent on two staff for transfers. The current Care Plans and Nursing Progress	F 0558	F558 - Reasonable Accommodations Needs/Preferences: Plan of Correction Immediate Action Taken: Resident #3 has been assessed thoroughly by PT for proper wheelchair and wheelchair in place. and no harm resulted from the alleged deficient practice. A suitable wheelchair has been promptly provided for Resident #3 to meet their needs. Broader Assessment of Affected Population: Audit completed by UM/Designee for residents to make sure that we have wheelchair in place for residents on admission. All dependent residents who could potentially be affected by the alleged deficient practice have been assessed. No harm has been identified for any of these residents. Proactive Measures for Prevention: All dependent residents' care plans have been reviewed and updated as necessary to ensure proper inclusion of assistive devices. In-service education has been provided to both nursing and therapy staff to reinforce awareness of resident preferences	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Notes were reviewed and there was no indication Resident 3 had refused to get out of bed. During an interview on 10/2/2024 at 2:34 P.M., QMA 3 indicated Resident 3 did not get up from bed because he did not have a chair. She had taken care of Resident 3 a couple of weeks ago and had gotten him up out of bed. She had gone down to therapy and asked for a wheelchair. She indicated she had returned it when she was done. She had asked the therapy department why Resident 3 did not have a wheelchair and they told her there was a "process" to getting a chair. During an interview on 10/4/2024 at 10:07 A.M., CNA 12 indicated she had worked at this facility for about four years and had taken care of Resident 3 frequently. CNA 12 indicated Resident 3 did not get up and did not have a chair. Although she was aware Resident 3 had been assisted out of bed by QMA 3 a few weeks ago, she did not offer to get him out of bed when she cared for him. During an interview on 10/4/2024 at 10:19 A.M., the Director of Rehab indicated the last time he was in physical therapy (PT) and occupational therapy (OT) was in 2022. She indicated Resident 3 did not know why he did not have a chair, but he should have had one. She indicated some residents preferred to stay in bed. An OT Discharge Summary, dated 8/15/2022-9/8/2022, indicated that he owned a Broda chair (a high back reclining chair with adjustable supports). On 10/4/2024 at 1:41 P.M., the Administrator indicated the facility did not have a policy related to accommodation of resident's needs.		and needs related to assistive devices and accommodation requirements. Monitoring and Follow-up: The Director of Nursing (DON) or designee will conduct reviews of accommodation needs for 5 dependent residents weekly for 4 weeks. After the initial phase, reviews will be done monthly for 5 months. To assure that wheelchairs are in place for residents on admit. Findings from these reviews will be discussed during the QAPI (Quality Assurance and Performance Improvement) meetings to determine trends and implement any necessary improvements for ongoing compliance. Target Compliance Date: 11/7/2024 Full compliance with F558 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0582 SS=D Bldg. 00	3.1-3(v)(1) 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form was provided following the end of Medicare skilled services for 1 of 1 resident who discharged from Medicare services and remained in the facility. (Resident 45) Finding includes: During a review of Beneficiary Notification forms, conducted on 10/4/2024 at 8:45 A.M., a Notice of Medicare Non-Coverage (NOMNC) form had been provided to Resident 45 on 6/26/2024 and indicated the resident's Medicare coverage was ending on 6/28/2024. There was no SNF-ABN (a form that informs a beneficiary that medicare may not pay for a service or item they intend to receive) provided to Resident 45. During an interview on 1/4/2024 at 8:54 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form was blank in response to whether Resident 45 received the SNF-ABN form. Resident 45 was provided a Notice of Medicare Non-Coverage (NOMNC) Form which indicated Resident 45's Medicare coverage would end on 6/28/2024. On 10/4/2024 at 9:52 A.M., the Social Services Director indicated Resident 45 remained in the facility and did not receive a SNF-ABN form.	F 0582	F582 - Medicaid/Medicare Coverage/Liability Notice: Plan of Correction Immediate Action Taken: Resident #45 has been assessed, and no harm resulted from the alleged deficient practice. The appropriate form regarding discharge from Medicare skilled services has been provided to Resident #45. Broader Assessment of Affected Population: Audit completed by BOM/Designee of residents who have been discharged from Medicare skilled services since 10/1/24 to assure that form has been provided for residents who discharged from Medicare services. Each of these residents has been assessed, and no harm has been identified. All residents discharged from Medicare skilled services since 10/1/24 have been provided with the required notice of discharge from Medicare (SNF-ABN form Corrective Measures Implemented: Education has been provided to the Business Office Manager and Medical Records staff regarding the process for providing the SNF-ABN form to residents	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 10/4/2024 at 11:10 A.M., the Administrator provided the policy titled "Beneficiary Liability Protection Notices ABN," dated 7/2018, and indicated it was the one currently being used by the facility. The policy did not indicate when a SNF-ABN form should have been provided to the resident. 3.1-4(f)(2)		following the end of Medicare skilled services. Ongoing Monitoring and Quality Assurance: The Executive Director (ED) or designee will review all residents discharged from Medicare skilled services to ensure the proper forms are provided. This review will occur weekly for 4 weeks and then monthly for 5 months. Findings from these reviews will be reported to the QAPI Committee for further review and recommendations over the next 6 months to ensure sustained compliance. Target Compliance Date:11/7/2024 Full compliance with F582 will be achieved by November 7, 2024.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to provide the resident, or the resident's representative, with a notice of transfer form for 2 of 2 residents reviewed for hospitalization. (Residents 8 and 59) Findings include: 1. A record review was completed on 10/3/2024 at 2:47 A.M. for Resident 8. Diagnoses included type 2 diabetes mellitus with neuropathy, bladder cancer, anxiety and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 7/10/2024, indicated Resident 8's cognition was intact.	F 0623	F623 - Notice Requirements Before Transfer/Discharge: Plan of Correction Immediate Action Taken: Residents #8 and #59 have been thoroughly assessed, and no harm resulted from the alleged deficient practice. Both residents have now been provided the required notice of transfer form. Broader Assessment of Affected Population: Audit completed by UM/Designee of resident's who have discharged since 10/1/24 to assure that residents who have discharged to	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 9/30/2024 at 2:30 P.M., Resident 8 indicated he had been hospitalized a few months ago but did not remember the specific date. Resident 8 had been sent to the emergency room and was admitted to the hospital on the following dates: -2/21/2024. -3/11/2024. -8/12/2024. The record lacked documentation the facility had provided Resident 8 a Notice of Transfer/Discharge for any of the hospitalizations. During an interview on 10/3/2024 at 2:35 P.M., the Executive Director (ED) indicated there was no documentation the Notice of Transfer/Discharge form was provided to Resident 8. 2. A record review was completed on 10/02/2024 at 1:34 P.M. for Resident 59. Diagnoses included, but were not limited to: end stage renal disease, chronic obstructive pulmonary disease and type 1 diabetes with neuropathy. A Quarterly Minimum Data Set (MDS) assessment for Resident 59 indicated his cognition was intact. During an interview on 10/01/2024 at 9:07 A.M. Resident 59 indicated he had been hospitalized several times but did not know the dates. Resident 59 was sent to the emergency room and hospitalized on the following dates: -6/10/24 -7/1/24		the hospitalized have been provided with notice of transfer have been identified as having potential to be affected by the alleged deficient practice. Each of these residents has been assessed, and no harm has been found. All residents discharged since 10/1/24 have now been provided with the proper notice of transfer form. Corrective Measures Implemented: Education has been provided to Social Services, Medical Records, and Nursing staff regarding the requirements for providing the notice of transfer form to residents before discharge or transfer. Ongoing Monitoring and Quality Assurance: The Executive Director (ED) or designee will review all discharged residents weekly for 4 weeks to ensure that the notice of transfer form has been provided. After the initial phase, reviews will continue monthly for 5 months. Findings from these reviews will be reported to the QAPI Committee for further review and recommendations over the course of 6 months to ensure ongoing compliance. Target Compliance Date: 11/7/2024 Full compliance with F623 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	-7/31/24 -9/10/24. The record lacked documentation the facility had provided Resident 59 a Notice of Transfer/Discharge form for any of the hospitalizations. During an interview on 10/3/2024 at 2:35 P.M., the ED indicated there was no documentation the Notice of Transfer/Discharge form was provided to Resident 59. On 10/4/2024 at 2:21 P.M. the ED provided a current policy, dated 12/12/23 and titled, "Transfer & Discharge." The policy indicated, "...Emergency Transfer/Discharge - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified)...." "...Provide a notice of transfer and the facilities bed hold policy to the resident and representative as indicated...." 3.1-12(8)(D)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to provide the resident, or the resident's representative, with a copy of the Bed Hold Policy when sent to the hospital for 2 of 2 residents reviewed for hospitalization. (Residents 8 and 59) Findings include: 1. A record review was completed on 10/3/2024 at 2:47 A.M. for Resident 8. Diagnoses included type 2 diabetes mellitus with neuropathy, bladder	F 0625	F625 - Notice of Bed Hold Policy Before/Upon Transfer: Plan of Correction Immediate Action Taken: Residents #8 and #59 have been assessed, and no harm resulted from the alleged deficient practice. Both residents have been provided with a copy of the bed hold policy as required. Broader Assessment of Affected	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cancer, anxiety and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 7/10/2024, indicated Resident 8's cognition was intact. During an interview on 9/30/2024 at 2:30 P.M., Resident 8 indicated he had been hospitalized a few months ago but did not remember the specific date. Resident 8 was sent to the emergency room and admitted to the hospital on the following dates: -2/21/2024. -3/11/2024. -8/12/2024. The record lacked documentation the facility provided Resident 8 a copy of the Bed Hold Policy for any of the hospitalizations. During an interview on 10/3/2024 at 2:35 P.M., the Executive Director (ED) indicated there was no documentation a copy of the facility Bed Hold Policy was provided to Resident 8. 2. A record review was completed on 10/02/2024 at 1:34 P.M. for Resident 59. Diagnoses included, but were not limited to: end stage renal disease, chronic obstructive pulmonary disease and type 1 diabetes with neuropathy. A Quarterly Minimum Data Set (MDS) assessment for Resident 59 indicated his cognition was intact. During an interview on 10/01/2024 at 9:07 A.M. Resident 59 indicated he had been hospitalized several times but did not know the dates.		Population: Audit was completed by UM/Designee of residents discharged since 10/1/24 to assure that a copy of bed hold policy was provided upon discharge to the hospital. These residents have been assessed, and no harm has been identified. All residents discharged since 10/1/24 have now been provided with a copy of the bed hold policy. Corrective Measures Implemented: Education has been provided to Social Services, Medical Records, and Nursing staff regarding the proper communication and provision of the bed hold policy to residents before or upon transfer. Ongoing Monitoring and Quality Assurance: The ED or designee will review all residents discharged weekly for 4 weeks to ensure they have been provided the bed hold policy. Afterward, reviews will be conducted monthly for 5 months. Findings will be reported to the QAPI Committee for review and recommendations over the next 6 months to guarantee compliance with this requirement. Target Compliance Date: 11/7/2024 Full compliance with F625 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 59 had been sent to the emergency room and hospitalized on the following dates: -6/10/24 -7/1/24 -7/31/24 -9/10/24. The record lacked documentation the facility provided Resident 59 a copy of the Bed Hold Policy for any of the hospitalizations. During an interview on 10/3/2024 at 2:35 P.M., the Executive Director (ED) indicated there was no documentation a copy of the Bed Hold Policy was provided to Resident 59. On 10/4/2024 at 2:21 P.M. the ED provided a current policy, dated 12/12/2023 and titled, "Bed Hold." The policy indicated, "...In the event of an emergency transfer of the resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated on the State's plan...." 3.1-12(a)(25)(26)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to develop a person-centered care plan regarding fluid needs for 1 of 18 residents whose care plans were reviewed. (Resident 8) Finding includes: A record review was completed on 10/01/2024 at 2:25 P.M. for Resident 8. Diagnoses included type 2 diabetes mellitus with neuropathy and congestive heart failure.	F 0656	F656 - Develop/Implement Comprehensive Care Plan: Plan of Correction Immediate Action Taken: Resident #8 has been assessed, and no harm resulted from the alleged deficient practice. The resident's care plan has been thoroughly reviewed and updated to reflect current fluid needs. Broader Assessment of Affected	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Quarterly Minimum Data Set (MDS) assessment, dated 7/10/2024, indicated Resident 8's cognition was intact. Physician's Orders for Resident 8 included, but were not limited to: -6/28/2024 2000 milliliter (ml) daily fluid restriction for edema and congestive heart failure. -4/3/2024 Furosemide 40 milligrams (mg) by mouth two times a day related to hypertensive heart disease and congestive heart failure. A current Care Plan, initiated on 9/12/2022, indicated Resident 8 was at risk for a fluid imbalance related to acute kidney failure and diuretic use. Interventions included, but were not limited to: staff was to educate the resident and family on the importance of the fluid restriction, as well as the risks and the potential negative outcomes of not adhering to the recommended fluid restrictions. There were no specific instructions regarding the amount of fluids each shift and department were allotted to maintain the ordered fluid restrictions. During an interview on 10/04/2024 at 9:42 A.M., the Unit Manager indicated the fluid restriction should have been broken down as to how much each shift and department had available per day, and the care plan should have included this information. 3.1-35(d)(1)(2)(A)(B)		Population: Audit completed by UM/Designee of residents with fluid restrictions to assure fluid restrictions have been identified for each shift to identify allotted amounts each shift is allowed with care plans updated as needed. No current residents are on fluid restrictions. Each of these residents has been assessed, and no harm has been identified. Corrective Measures Implemented: Education has been provided to both Dietary and Nursing staff on how to manage and implement fluid restrictions, ensuring they understand proper procedures for documenting and updating care plans related to fluid needs. Ongoing Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will review all orders for fluid restrictions weekly for 4 weeks to ensure proper care plan updates and implementation. After the initial phase, reviews will be conducted monthly for 5 months. Findings from these reviews will be reported to the QAPI Committee for evaluation and further recommendations to ensure ongoing compliance with care planning for residents' fluid needs. Target Compliance Date: 11/7/2024 Full compliance with F656 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure care plan conferences were completed every quarter for 4 of 4 residents reviewed for care plans. (Residents 13, 8, 59 & 26) Findings include: 1. During an interview on 9/30/2024 at 2:21 P.M., the family of Resident 13 indicated the resident had not had a care plan conference for the 2024 year. On 10/3/2024 at 9:05 A.M., a record review was completed for Resident 13. The record indicated the resident had been admitted to the facility on 3/20/2023 and a care conference was completed on 4/14/2023. The record lacked documentation a care plan conference had been completed for the 2024 year.2. During an interview on 10/1/2024 at 11:04 A.M., Resident 26 indicated she had not had a care plan meeting. A record review was completed on 10/1/2024 at 11:40 P.M., for Resident 26. Diagnoses included, but not limited to: end stage renal disease and peripheral vascular disease. During an interview on 10/3/2024 at 1:59 P.M., the Social Service Director indicated care plan meetings were documented under the evaluation tab titled, "IDT care plan conference summary." She indicated Resident 26 should have had a care plan conference in June or July (of 2024).3. During an interview on 9/30/2024 at 2:25 P.M. Resident 8 indicated he had not been to a Care Conference. A record review for Resident 8 was completed on	F 0657	F657 - Care Plan Timing and Revision: Plan of Correction Immediate Action Taken: Residents #8, #13, #26, and #59 have been assessed, and no harm resulted from the alleged deficient practice. Each of these residents has completed their care plan conference for the current quarter. Broader Assessment of Affected Population: Audit completed by Social Services Director/Designee of care conferences to assure that quarterly care conferences have been completed. All residents either have completed or are scheduled to complete their care plan conference for this quarter. Each resident has been assessed, and no harm has been identified. Corrective Measures Implemented: Education has been provided to Social Services staff regarding the importance of maintaining and adhering to care plan conference schedules, ensuring timely updates and revisions are made as needed. Ongoing Monitoring and Quality Assurance: The Executive Director (ED) or designee will review the care plan conference schedule weekly for 4 weeks to ensure timely conferences and revisions are	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/01/2024 at 2:25 P.M. Diagnoses included type 2 diabetes mellitus with neuropathy, bladder cancer, anxiety and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 7/10/2024, indicated Resident 8's cognition was intact and the resident had participated in planning and goal setting. An IDT Care Conference Summary, dated 1/22/2024, indicated a conference had been held and the resident was in attendance. The record lacked any further meetings or care conferences since that date. During an interview on 10/4/2024 at 2:51 P.M., the Unit Manager indicated Care Conferences had not taken place for Resident 8 as required. 4. During an interview on 10/1/2024 at 8:55 A.M., Resident 59 indicated he did not think he had ever been invited to a Care Conference. A record review was completed on 10/02/2024 at 1:34 P.M. for Resident 59. Diagnoses included, but were not limited to: end stage renal disease, chronic obstructive pulmonary disease and type 1 diabetes with neuropathy. A Quarterly Minimum Data Set (MDS) assessment for Resident 59 indicated his cognition was intact. The assessment indicated the resident had participated in the assessment and goal setting. On a Significant Change MDS assessment, dated 5/7/2024, Resident 59 had indicated it was very important to have a relative or friend involved in discussions about his care. On 9/5/2024 there was documentation a care plan meeting had taken place and Resident 59 had		held. Following this, reviews will be conducted monthly for 5 months. Findings from these reviews will be reported to the QAPI Committee for further review and recommendations to ensure sustained compliance over the next 6 months. Target Compliance Date: 11/7/2024 Full compliance with F657 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attended. The record lacked any documentation care plan meetings had taken place between 9/1/2023 and 9/5/2024. During an interview on 10/4/2024 at 2:51 P.M., the Unit Manager indicated Care Conferences had not taken place for Resident 59 as required. On 10/4/2024 at 2:51 P.M. the Unit Manager provided a current policy, dated 12/12/2023 and titled, "Comprehensive Care Plan." The policy indicated, "...The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: The resident and the resident's representative, to the extent practicable....." 3.1-35(e)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record review, the facility failed to ensure resident were assisted with personal hygiene and showers for 3 of 4 records reviewed for Activities of Daily Living (ADL). (Resident 3 & 24) Findings include: 1. During a family interview on 9/30/2024 at 3:08 P.M., the responsible party indicated he did not think Resident 3 had been getting up out of bed to be given a shower. During an observation on 10/1/2024 at 9:53 A.M., 10/3/2024 at 9:09 A.M. and on 10/4/2024 at 9:03 A.M., Resident 3 had long finger nails with a brown substance under them.	F 0677	**F677 - ADL Care Provided for Dependent Residents: Plan of Correction** **Immediate Action Taken**: Residents #3 and #24 have been assessed, and no harm resulted from the alleged deficient practice. Both residents have been assisted with personal hygiene care, including receiving showers. **Broader Assessment of Affected Population:** Audit was completed by UM/Designee of residents requiring assistance with showers to assure that residents showers have been completed. All	11/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A record review was completed on 10/2/2024 at 1:37 P.M., for Resident 3. Diagnoses were included, but not limited to: hemiplegia, unspecified affecting left dominant side, vascular dementia, unspecified severity, with other behavioral disturbance and acquired absence of right leg below knee. A Quarterly Minimum Data Set (MDS) assessment, dated 9/25/2024, indicated Resident 3 had severe cognitive impairment, had limited range of motion to one side of his body and bathing and personal hygiene needs were not documented on the assessment. A current Care Plan, dated 6/23/2019, titled "Activities of DailyLiiving", had interventions including bathing/showering and nail care on bath day, bathing/showering staff to provide assist. A current Care Plan, initiated on 8/17/2021, titled "At Risk for Adverse Consequences: Refused Hygiene after Bathing". Interventions included, but were not limited to: document behaviors and if resident becomes combative or resistive, postpone care/activity and allow resident to regain their composure and reapproach as needed. Resident 3 was scheduled every Monday and Thursday evening for a shower. A review of recent Nursing Progress Notes did not indicate he had refused care. The documentation for showers for Resident 3, from 9/1/2024 - 10/1/2024, indicated he had not received a shower. Refusal of care/showers was not documented. The bathing section indicated he was dependent for bathing. A review of behavior charting indicated there had		residents' shower schedules and care plans have been reviewed and updated as necessary to ensure they are reflective of personal hygiene needs. Each resident has been assessed, and no harm has been identified. The facility will implement routine, unannounced direct observations of resident hygiene care, including showers, grooming, and general personal hygiene. Observations will be conducted by designated staff members to ensure that hygiene needs are met in a timely and respectful manner. Observations will be recorded daily, and any identified issues will be immediately addressed. **Corrective Measures Implemented:** Education has been provided to nursing staff regarding the importance of adhering to shower schedules and assisting residents with personal hygiene in accordance with their care plans. **Ongoing Monitoring and Quality Assurance:** A monthly review of hygiene-related observations, documentation, and resident/family feedback will be conducted as part of the facility's ongoing quality assurance program. The goal is to identify trends or recurring issues that need to be addressed and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been no documentation of rejection of care or any behaviors for the past 30 days, 9/1/2024 - 10/1/2024. A review of bathing/bed bath, dated 9/1/2024 -10/2/2024, indicated Resident 3 had received five complete bed baths, on 9/2/2024, 9/5/2024, 9/19/2024, 9/23/2024 and 9/30/2024. A review of shower sheets indicated he had received a bed bath on 9/19/2024. During an interview on 10/2/2024 at 2:34 P.M., QMA 3 indicated when she performed morning care she washed the residents face, underarms and peri area, let the resident pick out their outfit then dressed the resident, set the resident up for oral care and changed the sheets. During an interview on 10/4/2024 at 10:07 A.M., CNA 12 indicated when she provided morning care, she assisted with washing the residents up for the day and dressed them. She indicated she had provided Resident 3 a shave, washed his face and peri area, pulled him up in bed and assisted him with his breakfast. She had not looked at his nails and had not seen the dirt or long length of his nails. She indicated if a resident refused a shower, she documented it in the point of care (POC) and informed the nurse. She indicated Resident 3 had not had any behaviors or refusals. During an interview on 10/4/2024 at 11:12 A.M., the DON indicated refusals should be documented in the POC or in the progress notes. She indicated she did not see documentation for bathing on 9/9/2024, 9/12/2024, 9/16/2024 and 9/26/2024 and he should have been offered bathing. Every resident should be offered two showers a week. She would have expected the		ensure continuous improvement in resident hygiene care **Target Compliance Date: 11/18/2024** Full compliance with F677 will be achieved by November 18, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan of care to reflect his preference and it did not. On 10/3/2024 at 10:54 A.M., the Unit Manager provided a policy titled, "Interdisciplinary Team (IDT) Risk Review Meeting," dated 1/2/2024, and indicated the policy was the one currently used by the facility. The policy indicated, "3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises....." 2. During an observation on 9/30/2024 at 2:15 P.M., Resident 24 was in the hallway by the Activities room and her bottom teeth had a build-up of a thick white substance. During an observation on 10/1/2024 at 9:04 A.M., Resident 24 had a brown substance around her mouth and her bottom teeth had a build-up of a thick white substance. During an observation on 10/2/2024 at 2:23 P.M., Resident 24's bottom teeth had a build-up of a thick white substance. Resident 24's record review was completed on 10/2/2024 at 2:45 P.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis affecting right side, aphasia, dysphagia, vascular dementia, major depressive disorder and generalized anxiety disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 8/28/2024, indicated Resident 24 had severe cognitive impairment, was rarely able to make herself understood, sometimes understood others and required supervision or assistance with oral care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A current Care Plan, initiated on 11/21/2021 and revised on 1/11/2023, indicated Resident 24 needed assistance with activities of daily living related to a personal history of a cerebrovascular accident resulting in right sided hemiplegia. The Care Plan included a goal for the resident to have her daily care needs met with the assistance of staff. Interventions included, but were not limited to: Staff to assist/encourage oral care twice daily and as needed. Notify nurse of any redness, irritation or complaints of oral pain.

A current Care Plan, initiated on 8/1/2021, indicated Resident 24 had oral/dental health problems related to missing teeth. The goal of the Care Plan was for the resident to be free of infection, pain or bleeding in the oral cavity. Interventions to the Care Plan included, but were not limited to: Provide mouth care or encourage resident to perform oral care twice daily and as needed.

Documentation of oral care for Resident 24, for the past month indicated oral care had only been offered once a day for the following dates: 9/6/2024, 9/7/2024, 9/8/2024, 9/9/2024, 9/10/2024, 9/12/2024, 9/13/2024, 9/14/2024, 9/22/2024, 9/23/2024, 9/24/2024, 9/25/2024, 9/30/2024 and 10/1/2024.

There was no documentation Resident 24 had refused oral care.

During an interview on 10/3/2024 at 2:34 P.M., QMA (Qualified Medication Aid) 3 indicated oral care was part of AM (morning) and PM (evening) care. She indicated Resident 24 was not able to brush her own teeth without encouragement and most days, the resident required the staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	manually brush her teeth for her. QMA 3 indicated the resident's teeth appeared like they had not been brushed due to the amount of build-up on the resident's bottom teeth. On 10/3/2024 at 2:52 P.M., the Unit Manager provided an undated policy titled, "Oral Care", and indicated it was the policy used by the facility. The policy indicated, "It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases...." 3.1-38 (a)(2)(A) 3.1-38 (a)(3)(C) 3.1-38 (a)(3)(E)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on interview, observation and record review, the facility failed to follow the Physician's orders related to flushing a G-tube (gastrointestinal tube) and changing the tubing for 2 of 2 residents who were reviewed for a G-tube. (Resident 222 & 7) Findings include: 1. During an interview on 10/1/2024 at 9:57 A.M., Resident 222 indicated his G-tube was not being used for nutrition or medications but it was supposed to be flushed twice a day. He indicated his G-tube had only been flushed once since his admission on 9/24/2024. During an interview on 10/2/2024 at 10:40 A.M., Resident 222 indicated his G-tube had not been flushed the last two days.	F 0693	F693 - Tube Feeding Management/Restore Eating Skills: Plan of Correction Immediate Action Taken: Residents #7 and #222 have been thoroughly assessed, and no harm resulted from the alleged deficient practice. Their gastrostomy tubes (g-tubes) have been flushed, and the tubing has been changed according to best practices. Broader Assessment of Affected Population: Audit was completed by UM/Designee of residents with g-tubes to assure that tubes are being flushed, and labeled when hung, and syringe for flushing is changed every day. All residents with g-tubes have had their	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 10/2/2024 at 10:41 A.M., no medical equipment for flushing a G-tube was located in the residents room, bathroom or trash can. Resident 222's record review was completed on 10/2/2024 at 11:45 A.M. Diagnoses included, but were not limited to: paraplegia, fusion of lumbar spine, neurogenic bowel and neuromuscular dysfunction of bladder. A current Physician's order, dated 9/26/2024, indicated the resident's G-tube was to be flushed with 60 milliliters of water every shift. A current Care Plan, initiated on 9/26/2024, indicated the resident was at risk of complications of tube feeding and had a goal of being free from complications of G-tube flushes. Interventions included, but were not limited to: Check for tube placement and gastric contents/residual volume per facility protocol and record, and provide water flushes per Physician's orders. Resident 222's record lacked the documentation he had refused any G-tube flushes. The October 2024 TAR (Treatment Administration Record) indicated Resident 222's G-tube had been flushed twice on 10/1/2024 and once on 10/2/2024. During an interview on 10/02/2024 at 11:50 A.M., Resident 222 indicated staff had not flushed his G-tube in the past two days. During an interview on 10/2/2024 at 11:55 A.M., LPN 2 indicated she had flushed Resident 222's G-tube earlier in the morning. However, she was unable to locate the equipment she had used after the flush. She then indicated she had not flushed		physician orders and care plans reviewed and updated as necessary to ensure alignment with current best practices for tube feeding management. Each resident with a g-tube has been assessed, and no harm has been identified. Corrective Measures Implemented: Education has been provided to nursing staff regarding the proper techniques for g-tube flushes and changing tubing, including following established protocols to prevent complications and ensure safety. Ongoing Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will review g-tube management, including flushing and tubing changes, for all residents with g-tubes weekly for 4 weeks to ensure compliance. Afterward, reviews will be conducted monthly for 5 months to ensure ongoing adherence to standards. Findings from these reviews will be reported to the QAPI Committee for further review and recommendations over the next 6 months to ensure ongoing compliance. Target Compliance Date: 11/7/2024 Full compliance with F693 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	his G-tube that morning and marked the documentation "complete" by mistake. She indicated treatments should not be documented as completed in the medical record until after the task had been completed. During an interview on 10/2/2024 at 11:57 A.M., the Unit Manager indicated she knew the resident's G-tube had been flushed yesterday because she was the one that had flushed his G-tube during the second shift. When asked if it was her initials on the October 2024 TAR for the October 1st second shift G-tube flush, she indicated it was not her initials and she had not signed off on the TAR. She indicated treatments should be signed off in the medical record after the treatment was performed and by the staff member who completed the treatment. 2. During an observation on 10/1/2024 at 9:09 A.M., there was a bottle of tube feeding formula for Resident 7 hanging with a date of 10/1 and time of 0500 in red marker on the side of the bottle. The rest of the label to indicate the resident's name, room number, rate of infusion and nurse's initials were left blank. There was also a bag of clear liquid, dated 10/1 at 0500 hanging on the pole. During an observation on 10/2/2024 at 9:00 A.M., the bag with clear liquid dated 10/1 with a time of 0500 in red marker and a bottle of tube feeding formula dated 10/2 with a time of 2 A.M. were noted hanging. A package with a syringe was dated 6/21/2024 without a name. A record review was completed on 10/2/2024 at 9:39 A.M., for Resident 7. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side and vascular dementia.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A Physician's Order, dated 3/28/2024, indicated to change the container, G-tube tubing and syringe every 24 hours, every night and to label with the resident's name and date.

During an interview on 10/2/2024 at 9:39 A.M., RN 11 indicated the tube feeding formula and the bag of clear liquid had different dates and the system should have been changed daily with labels filled out and on the syringe. She indicated the syringe was just opened this morning and she did not put the resident's name or date on the syringe. She indicated she had not see the 6/21/24 date.

On 10/2/2024 at 12:19 P.M., the Unit Manager provided an undated policy, titled, "Documentation in the Medical Record" and indicated it was the policy used by the facility. The policy indicated, "...Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy...b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care...."

On 10/2/2024 at 12:19 P.M., the Unit Manager provided a policy titled, "Enteral Feeding," dated 1/2/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible....."

3.1-44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, record review and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 4 residents (Resident 28 & 35) observed during medication pass. There were 25 opportunities observed with 2 medication errors, resulting in a medication error rate of 8 percent. Findings include: 1. During an observation and interview on 10/2/2024 at 9:15 A.M., RN 11 did not have Resident 28's fluticasone propionate available to administer and indicated she would call the pharmacy. A record review was completed on 10/2/2024 at 10:00 A.M., for Resident 28. Diagnoses included but were not limited to: chronic pain syndrome and allergies. A Physician's Order, dated 3/28/2024, indicated Fluticasone Propionate suspension 50 micrograms (MCG) one spray in each nostril one time a day for allergies. 2. During an observation and interview on 10/2/2024 at 10:11 A.M., for Resident 35, RN 11 indicated she did not know why there were two inhalers in the opened bag in the medication drawer. She indicated neither inhaler had an opened date on them, she was not going to administer the medication. She indicated she would notify pharmacy to send a new one. A record review was completed on 10/2/2024 at 10:05 A.M., for Resident 35. Diagnoses included	F 0759	F759 - Free of Medication Error Rates 5 Percent or More: Plan of Correction Immediate Action Taken: Residents #28 and #35 have been assessed, and no harm resulted from the alleged deficient practice. Both residents' medication passes have been observed by staff, and no medication errors were identified. Broader Assessment of Affected Population: Audit completed by UM/Designee of Licensed Nurses medication passes to assure that medications are passed per physician's orders. Medication passes have been observed across all medication carts to ensure that no errors have occurred. All residents have been identified as having potential to be affected by the alleged deficient practice. Each resident has been assessed, and no harm has been identified. Corrective Measures Implemented: Education has been provided to all nurses and Qualified Medication Aides (QMAs) on proper medication administration techniques, including strategies for reducing medication errors and adhering to the "Five Rights" of medication administration (Right Resident, Right Medication, Right	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	but were not limited to: chronic obstructive pulmonary disease. A Physician's Order, dated 8/9/2023, indicated Albuterol Sulfate 90 mcg, give two puffs three times a day. During an interview on 10/3/2024 at 2:28 P.M., the DON indicated the Albuterol was available in the emergency kit (EDK) located in the medication room. If a medication was not available in the EDK, the nurse should notify the pharmacy. The DON indicated their back up pharmacy was (name of two local pharmacies) and medications could be provided in about four hours. On 10/4/2024 at 11:22 A.M., the DON provided a policy titled, "Medication Administration," dated 1/2/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 21. Medications that are not readily available for administration will be obtained from the Emergency Kit, drop shipped from the pharmacy, or obtained from an alternative pharmacy....." 3.1-48(c)(1)		Dose, Right Time, and Right Route). Ongoing Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will observe one medication pass weekly for 4 weeks to monitor compliance with correct medication administration procedures. After the initial period, monthly observations will be conducted for 5 months. Findings from these observations will be reported to the QAPI Committee for further review and recommendations to ensure sustained compliance over the next 6 months. Target Compliance Date: 11/7/2024 Full compliance with F759 will be achieved by November 7, 2024.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review the facility failed store and prepare food in a sanitary manner related to labeling and dating of opened food in the walk-in cooler and disposing of expired spices in 1 of 1 kitchens observed. This had the potential to effect 72 of 74 residents who received their meals from the kitchen. Finding includes:	F 0812	F812 - Food Procurement, Store/Prepare/Serve-Sanitary: Plan of Correction Immediate Action Taken: All residents who receive meals from the kitchen have been assessed, and no harm has resulted from the alleged deficient practice.	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. During the initial kitchen tour with the DM (Dietary Manager) on 9/30/2024 at 9:44 A.M., the following food items were observed in the walk-in cooler: -Eight single serve cheese cups did not have a made on or use by date. -Half a bag of salad mix was open but did not have an opened on or use by date. -A bag of celery was open and did not have an opened on or use by date. -7 bowls of salad with clear cellophane wrap did not have a made on or use by date. 2. During the initial kitchen tour with the DM on 9/30/2024 at 9:52 A.M., the following food items were observed in the dry storage areas: - Whole celery seed was opened 7/7/23 and had an expiration date of 1/30/24. - Poultry seasoning was opened but had no opened on date and had an expiration date of 1/16/2021. - Cayenne pepper was opened but had no opened on date and had an expiration date of 6/25/2023. - Candy sprinkles was opened but had no opened on date and had an expiration date of 10/29/2023. During an interview on 9/30/2024 at 9:54 A.M., the DM indicated the bag of salad mix and bag of celery should have been labeled with an opened on and a discard date. The 8 cheese cups and 7 bowls of salad should have been labeled with the made on and discard date. All of the spices should have been discarded by the expiration date on the package. During an interview on 10/3/2024 at 1:30 P.M., the DDM (District Dietary Manager) indicated dry		The single cheese slices, half bag of salad, celery opened, poultry seasoning, cayenne pepper, and candy sprinkles were thrown out. Broader Assessment of Affected Population: All residents have the potential to be affected by the alleged deficient practice. Each resident has been assessed, and no harm has been identified. Audit was completed by Dietary Manager/Designee to assure that food is inspected to ensure that no food is stored or prepared in an unsanitary manner, particularly regarding the labeling and dating of opened food in the walk-in cooler and the disposal of expired spices. Corrective Measures Implemented: Education has been provided to dietary staff regarding proper food storage, labeling practices, and maintaining a clean and sanitary environment in line with food safety standards. Ongoing Monitoring and Quality Assurance: The Executive Director (ED) or designee will conduct weekly inspections of the kitchen for 4 weeks to ensure food is being stored and prepared in a sanitary manner, focusing on the labeling and dating of opened food and the disposal of expired items. After the initial period, monthly inspections will be conducted for 5 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	spices were good for three years after opening, but spices were not used past the manufactures expiration dates. The DM indicated the facility did not have a policy specific to spices. On 10/3/2024 at 2:52 P.M., the DM provided an undated policy titled, "Food Preparation", and indicated it was the policy currently used by the facility. The policy indicated, "... 17. All refrigerated, ready-to-eat Time/Temperature Control for Safety prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees Fahrenheit or less, will be labeled and dated with a "prepared date" (Day 1) and a "use by date" (Day 7)...." 3.1-21(i)(3)		Findings from these inspections will be reported to the QAPI Committee for further review and recommendations over the next 6 months. Target Compliance Date: 11/7/2024 Full compliance with F812 will be achieved by November 7, 2024.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure infection control practices were carried out appropriately for the storage of respiratory equipment, catheter care, blood sugar monitoring and cleaning of a glucometer for 3 of 3 residents observed for infection control. (Resident 13, 21 & 26) Findings include: 1. During an observation on 10/1/2024 at 11:14 A.M., QMA 14 cleaned Resident 26's finger with an alcohol wipe then fanned the area with her hand. When she returned to the medication cart, she placed the unsanitized glucometer in a basket on top of supplies used for blood sugar monitoring and walked away. During an interview on 10/1/2024 at 11:18 A.M.,	F 0880	F880 - Infection Prevention & Control: Plan of Correction Immediate Action Taken: Residents #13, #21, and #26 have been assessed, and no harm has resulted from the alleged deficient practice. Observations have been made to confirm that appropriate oxygen storage, catheter care, and blood sugar monitoring procedures are being followed based on the individual needs of these residents. Um received education on changing gloves and washing hands. Licensed Nurse was educated on making sure that Bi-Pap mask is cleaned and dried and placed in	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	QMA 14 indicated she was not sure if she could wave her hand over the finger and cleaning of the glucometer with a bleach wipe should have occurred after returning to the cart. 2. On 10/3/2024 at 9:05 A.M., a record review was completed for Resident 13. Diagnoses included, but were not limited to: urinary tract infection, human immunodeficiency virus, and obstructive reflux uropathy. A review of the Physician's Orders indicated Resident 13 had orders for Enhanced Barrier Precautions when engaging in high contact resident care activities and to cleanse the supra-pubic catheter site every shift with soap and water. During an observation of catheter care for Resident 13, on 10/3/2024 at 9:44 A.M., the Unit Manager and CNA 4 put on a gown, gloves, mask and face shield prior to entering Resident 13's room. The Unit Manager and CNA 4 rolled the resident to his right side to perform incontinence care prior to performing catheter care. A soiled bed pad was removed from under the resident and the residents' brief was partially removed. CNA 4 and the Unit Manager washed their hands and put on a clean pair of gloves. The Unit Manager removed cleansing wipes from a bag and began cleaning up the residents stool. A clean bed pad and brief were then placed on the resident with the staff wearing the same gloves used to clean up the resident's stool. During an interview on 10/3/2024 at 10:11 A.M., the Unit Manager indicated she changed her gloves twice during the observation and did not believe she had forgotten to change her gloves prior to placing a clean bed pad and brief on the		bag when not in use. The QMA was educated on cleaning of glucometer with bleach wipe after use. Broader Assessment of Affected Population: Audit was completed by UM/Designee of residents with Bi-Pap equipment to assure that mask is clean and bagged when not in use. Audit completed by UM/Designee of residents receiving incontinence care to assure hands are washed and gloves changed. Audit completed by UM/Designee of resident's blood sugar checks to assure that glucometer is being cleaned after use. All respiratory equipment is now being stored appropriately in accordance with infection control standards. Incontinence care has been observed for residents requiring catheter use to ensure proper infection control measures are in place. Blood sugar monitoring practices have been observed for residents who require this service, ensuring that infection control protocols, such as the proper cleaning of glucometers, are being followed. Corrective Measures Implemented: Education has been provided to all nursing staff regarding proper infection prevention practices, including the correct storage of respiratory equipment, best	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident. 3. During an observation on 9/30/2024 at 10:12 A.M. and on 10/3/2024 at 10:24 A.M., Resident 21's bipap mask was laying on his bed without a bag and with a brown substance surrounding the inside seal of the mask. During an observation on 10/2/2024 at 1:18 P.M., Resident 21's bipap mask was laying on the floor, next to his bed without a bag. During an interview on 10/2/2024 at 2:31 P.M., CNA 8 indicated the nurses were responsible for cleaning the resident's bipap mask and the mask should have been stored in a plastic bag. During an interview on 10/4/2024 at 2:07 P.M., the Unit Manager indicated all respiratory equipment, including oxygen tubing and masks were to be stored in a bag. On 10/2/2024 at 11:37 A.M., the DON provided a policy titled, "Blood Glucose Monitoring," dated 1/2/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 7. Clean the intended site with an alcohol pad and allow to dry completely....." On 10/2/2024 at 11:37 A.M., the DON provided a policy titled, "Glucometer Disinfection," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...Procedure: i. Retrieve (2) disinfectant wipes from container. j. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer thoroughly with the disinfectant wipe following the manufacturer's instructions. Allow the		practices for incontinence care, blood sugar monitoring, and the cleaning of glucometers. Ongoing Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will observe the storage of respiratory equipment for 5 residents, catheter care for 1 resident, blood sugar monitoring for 5 residents, and the cleaning of glucometers on each unit weekly for 4 weeks. Following the initial period, these observations will be conducted monthly for 5 months. Findings from these observations will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee for review and recommendations to ensure sustained compliance over the next 6 months. Target Compliance Date: 11/7/2024 Full compliance with F880 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	glucometer to air dry....." On 10/3/2024 at 11:48 A.M., the Unit Manager provided the policy titled, "Enhanced Barrier Precautions," undated, and indicated it was the policy currently being used by the facility. The policy indicated, "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms...." On 10/2/2024 at 2:48 P.M., a policy regarding bipap mask storage was requested but one was not provided prior to the survey exit. 3.1-18(l)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to maintain a safe and sanitary environment related to monitoring personal refrigerator temperatures and disposing of expired food in personal refrigerators for 3 of 3 residents who used personal refrigerators. (Residents 21, 44 & 45) Findings include: 1. During an observation on 9/30/2024 at 10:13 A.M., Resident 21's personal refrigerator had a temperature log form with the month labeled as August and no temperatures were recorded for any of the dates. During an observation on 9/30/2024 at 2:00 P.M., Resident 44's personal refrigerator had a temperature log form with the month labeled as August and no temperatures were recorded for	F 0921	F921 - Safe/Functional/Sanitary/Comfortable Environment: Plan of Correction Immediate Action Taken: Residents #21, #44, and #45 have been assessed, and no harm has resulted from the alleged deficient practice. Monitoring of refrigerator temperatures and food expiration dates in residents' personal refrigerators has been conducted to ensure a safe and sanitary environment. Broader Assessment of Affected Population: Audit was completed by UM/Designee of residents with personal refrigerators to assure temperature monitoring, and	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	any of the dates. During an observation on 9/30/2024 at 2:19 P.M., Resident 45's personal refrigerator had a temperature log form with the month labeled as July and had temperatures recorded only on 7/5/2024, 7/6/2024, 7/8/2024, 7/9/2024 and 7/10/2024. 2. During an observation on 9/30/2024 at 2:19 P.M., Resident 45's personal refrigerator contained the following expired food: - A pre-made salad with an expiration date of 9/20/2024. -Honey ham lunch meat with an expiration date of 9/13/2024. -Two chocolate pudding cups with an expiration date of 7/14/2024. -A squeeze bottle of Miracle Whip with an expiration of 9/5/2024. During an interview on 10/3/2024 at 8:41 A.M., the Social Services Director indicated the personal refrigerators were checked by "Magic Makers". Magic Makers was a system used by the facility that split all of the residents up into small groups and each group was assigned someone from management to check in on the resident. While the staff member was checking in on the resident, they were also to record the refrigerator temperatures and remove expired food. The refrigerator temperature log forms were kept on the refrigerator. During an interview on 10/03/24 at 10:28 A.M., the IED (Interim Executive Director) supplied the temperature log sheets for the month of September for Residents 21, 44 and 45, and indicated there were no other temperature log		expired food is removed. Regular monitoring of refrigerator temperatures and food expiration dates for all residents with personal refrigerators has been established to maintain a safe and sanitary environment. All residents with personal refrigerators have been identified as potentially affected by the alleged deficient practice. Each resident with a personal refrigerator has been assessed, and no harm has been identified. Corrective Measures Implemented: Education has been provided to the management team involved in the Hearts of Excellence program regarding the importance of monitoring refrigerator temperatures and food expiration dates to ensure compliance with safety and sanitation standards. Ongoing Monitoring and Quality Assurance: The Executive Director (ED) or designee will monitor 5 residents' personal refrigerators weekly for 4 weeks, followed by monthly checks for 5 months to ensure ongoing compliance with temperature and expiration date standards. Findings from these monitoring activities will be reported to the QAPI Committee for review and recommendations over the next 6 months to ensure sustained compliance. Target Compliance Date:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sheets for any other months. The ED indicated nursing staff were responsible for checking the temperatures and cleaning out any spills and throwing away expired food during the weekdays and Housekeeping checked the temperatures on the weekend. The IED indicated the temperature log forms were kept at the nurse's station. During an interview on 10/03/24 at 2:44 P.M. the Maintenance Director indicated maintenance did not check the temperatures of personal refrigerators. The rooms were split up through the management team and those members of staff checked the temperature. The log sheets were located on the refrigerators and he was not aware of there being a time when the temperature log sheets were stored at the nurse's station. During an interview on 10/04/2024 10:00 A.M., the Environment Services Director indicated housekeeping does not clean or record the temperatures of personal refrigerators. During an interview on 10/04/2024 at 10:50 A.M., the Unit Manager indicated the Magic Makers took the temperature of the personal refrigerators and cleaned out expired food. The current month's temperature log were kept on the refrigerators and then stored in the Unit Managers office when the month was over. The Unit Manager indicated Resident 45 did have expired food in her refrigerator and should not have had. On 10/3/2024 at 10:27 A.M., the IED supplied an undated policy title, "Resident Refrigerators" and indicated it was the policy currently used by the facility. The policy indicated, "... 2. Maintenance staff shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator... 4... c. Foods with use-by dates shall be discarded		11/7/2024 Full compliance with F921 will be achieved by November 7, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordingly. 3.1-19 (f)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t)(3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to maintain the health records of an employee related to a preemployment physical examination for 1 of 5 employees whose record were reviewed. (CNA 2) Finding includes: During an observation of the employee records on 10/3/2024 at 10:00 A.M., CNA 2's employment file did not contain a preemployment physical examination. During an interview on 10/4/2024 at 11:18 A.M., the Director of Human Resources indicated CNA 2's employment file did not have a preemployment physical examination but should have. The facility did not have a policy related to maintaining employee records. 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of (6) hours of	F 9999	F9999 - Personnel: Plan of Correction Immediate Action Taken: All residents have been assessed, and no harm has resulted from the alleged deficient practice. Monitoring of employee files to ensure the proper Broader Assessment of Affected Population: Audit was completed by HR/Designee of staff files to assure each staff member has the proper physical and required training. Regular monitoring of employee files has been established to maintain files and health records. All residents who reside within the facility have been identified as potentially affected by the alleged deficient practice. Each resident has been assessed, and no harm has been identified. Corrective Measures Implemented: Education has been provided to the HR director regarding the importance of monitoring employee files to ensure compliance with personnel file and health record standards. Ongoing Monitoring and Quality Assurance:	11/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to have an employee complete 3 hours of annual dementia training for 1 of 10 employees whose records were reviewed. (RN 10) Findings include: During an observation of the employee records on 10/3/2024 at 10:00 A.M., RN 10's employment file did not contain documentation to indicate she had completed her annual 3 hours of dementia training. During an interview on 10/4/2024 at 1:15 P.M., the Director of Human Resources indicated RN 10 did not complete her annual 3 hours of dementia training. The facility did not have a policy related to annual dementia training.		The HR Director under the guidance of the Executive Director (ED) will monitor 5 staff files weekly for 4 weeks, followed by monthly checks for 5 months to ensure ongoing compliance with personnel file and health record standards. Findings from these monitoring activities will be reported to the QAPI Committee for review and recommendations over the next 6 months to ensure sustained compliance. Target Compliance Date: 11/7/2024 Full compliance with F9999 will be achieved by November 7, 2024.	