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	01/11/2024

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 the Investigation of Complaints IN00425453, IN00424888, IN00424749, IN00423457 and IN00421638. Complaint IN00425453 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00424888 - No deficiencies related to the allegations are cited. Complaint IN00424749 - No deficiencies related to the allegations are cited. Complaint IN00423457 - No deficiencies related to the allegations are cited. Complaint IN00421638 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: January 8, 9, 10 & 11, 2024 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 4 Medicaid: 69 Other: 4 Total: 77	F 0000	F 0000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility requests paper compliance for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rayne Wise	Executive Director	01/26/2024

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.

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/17/24.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal			

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	or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure a resident's representative was notified timely, when there was an acute change in the resident's condition. (Resident F) Finding includes: On 1/8/24 at 11:10 A.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses were dementia and non-traumatic brain dysfunction. A Care Plan, dated 9/15/23, indicated the resident had advance directives and wished to be a full code. The interventions included but were not limited to: support resident/family with ongoing decisions, notify physician and representative of changes in the resident's condition. A Change of Condition Assessment form, dated 1/3/24 at 7:30 A.M., indicated at the time of the evaluation the resident's vital signs were: blood pressure 72/51, pulse 90, respirations 24 and	F 0580	F580 Notification of Changes 1) Immediate actions taken for those residents identified: Resident F no longer resides at the facility. Resident F's family was made aware of the change in her condition. 2) How the facility identified other residents: All residents with a change of condition have the potential to be affected by the alleged deficient practice. Audit completed by UM/Designee of residents identified with change of conditions to ensure that resident's representative was notified timely when there is a change in residents' condition. 3) Measures put into place/ System changes: Nursing staff were educated on Change of Condition Policy and Physician/Family Notification by	01/26/2024

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	temperature was 98.0. The resident's pulse oximetry was 98% on room air. The resident was a full code, however the resident had not been able to swallow, had labored/rapid breathing, had abnormal vital signs and had been lethargic. The recommendations stated "Palliative care/hospice with code status change". In addition, the form indicated Primary Care Provider responded with the following feedback: "...Recommendations of Primary Clinicians on 1/3/24 at 7:30 AM send to ER [Emergency Room] for eval [evaluation] et [and] Tx [Treatment] per son request ...Name of Family/Health Care Agent Notified: [name of resident's son] Date: 1/03/2024 Time: 4:30 PM ...." During an interview on 1/9/24 at 11:09 A.M., the Director of Nursing (DON) indicated she had documented the Change of Condition Assessment on 1/3/24 at 7:30 A.M., but had not notified the resident's son until 4:30 P.M. and it wasn't until 4:30 P.M. that she received the order to transfer the resident to a local emergency room per the son's request. On 1/9/24 at 10:26 A.M., the Administrator provided a policy titled "Change in Condition", dated October 2019, and indicated the policy was the one currently used by the facility. The policy indicated " ...Purpose: to ensure timely interventions for a change in a resident's condition. PROCEDURE: 2. Acute Change in Condition ...a. Any sudden or serious change in a resident's condition will be communicated to the physician. b. The responsible party will be notified that there has been a change in the resident's condition ...." 3.1-5(a)(2)		the DON on January 24 and January 25, 2024. With a focus on notification of resident's representative with a change in condition. 4) How the corrective actions will be monitored: The UM/Designee will complete random weekly audits five times a week for 6 months and then monthly ongoing. To ensure that resident's representative has been notified with any change in condition with findings submitted to the DON who will report findings to the QAPI Comm. for review and recommendations. 5) The DON is responsible for compliance.	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed received appropriate interventions when there had been an acute change of condition. (Resident F) Finding includes: On 1/8/24 at 11:10 A.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses were dementia and non-traumatic brain dysfunction. A Care Plan, dated 9/15/23, indicated the resident had advance directives and wished to be a full code. The interventions included but were not limited to: support resident/family with ongoing decisions, notify physician and representative of changes in the resident's condition. A Progress Note, dated 1/3/24 at 6:30 A.M., indicated "...Resident calmly resting in bed, R 24; T 98.0; P 90; B/P 72/51; O2 Sat 98% on room air. Resident is responsive to touch, only moans when being turned and repositioned. House NP (Nurse Practitioner) and DON (Director of Nursing) updated on resident's current condition. Will continue to monitor...." This Progress Note had been documented by LPN 2	F 0684	F684 Quality of Care 1) Immediate actions taken for those residents identified: No Longer resides at the facility. Resident F's family was made aware of the change in her condition. 2) How the facility identified other residents: Audit was completed by UM/Designee of residents with change of conditions to ensure we have appropriate interventions in place when there is an acute change in condition, and resident's representative is notified as soon as we have identified a change in condition. All residents with a change of condition have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: Nursing staff were educated on Change of Condition Policy and Physician/Family Notification by the DON on January 24 and January 25, 2024. With a focus on ensuring that we have appropriate	01/26/2024

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	A Change of Condition Assessment form, completed by the Director of Nursing and dated 1/3/24 at 7:39 A.M., indicated at the time of the evaluation the resident's vital signs were: blood pressure 72/51, pulse 90, respirations 24 and temperature was 98.0. The resident's pulse oximetry was 98% on room air. The resident was a full code, however the resident had not been able to swallow, had labored/rapid breathing, abnormal vital signs and was lethargic. The recommendations stated "Palliative care/hospice with code status change". In addition, the form indicated Primary Care Provider responded with the following feedback: "...Recommendations of Primary Clinicians on 1/3/24 at 7:30 AM send to ER [Emergency Room] for eval [evaluation] et Tx [Treatment] per son request ...Name of Family/Health Care Agent Notified: [name of resident's son] Date: 1/03/2024 Time: 4:30 PM ...." A Progress Note, dated 1/3/24 at 4:30 P.M., indicated the DON had telephoned the resident's son's to notify him of the change of condition and provided details such as, her blood pressure was low, respirations were elevated, worsening wounds, not swallowing and all those changes indicated "active death". The son became anxious on the phone and said he would call the DON later. A few minutes later, the facility received a phone call from a Special Investigator at APS (Adult Protective Services) stating she had received a call from Resident F's son and he wanted his mother "...sent out to ER for Eval et Tx [Evaluation & Treatment] per SS [social service] director. Order received et floor nurse notified...." A Progress Note, dated 1/3/24 at 6:00 P.M., indicated "...Order received to send resident to ER		interventions in place with a change in condition, and resident's representatives are notified as soon as we identify a change in condition. 4) The UM/Designee will complete random weekly audits five times a week for 6 months and then monthly ongoing to ensure that appropriate interventions are in place with a change in condition, and that resident's representative has been notified as soon as we identify a change in condition with findings submitted to the DON who will report findings to QAPI comm. For review and recommendations. 5) DON is responsible for compliance.	

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	[Emergency Room]... will be picking up resident in 20 minutes. Resident continues to respond only to touch, R 22, B/P 74/50, T98.1, P94, O2 Sat 96% on room air...." The ambulance arrived at 6:45 P.M. to transport the resident to the local ER. A Physician Order, dated 1/3/24 at 6:47 P.M., indicated to send the resident to the emergency room for an evaluation and treatment, per the son's request. NP Progress Note, dated 1/3/24, with no time of the assessment, indicated the reason for this visit had occurred due to the resident "declining and restless". Further assessment indicated "wound got worse over 2 weeks period and she suddenly declined from eating and need for hospice care. " ...Pt [patient] appears to be in no distress resting. She arouses but fall asleep ...she has a son who was her only family. He was notify and suggested she goes to hospital ...." Exam indicated no acute distress, respirations labored with clear auscultation, bowel sounds hypoactive and skin had normal temperature. The plan indicated to notify son, continue to monitor weight, continue physical therapy and occupational therapy as indicated. Additional text indicated to continue monitoring, continue medications and treatments. The hospital History & Physical, dated 1/3/24, indicated the patient was brought to the ER due to altered mental status and reported fever. During the transport the patient had seizure like activity, went unresponsive and was intubated. The resident's son arrived to the ER and had been updated on his mother's critical status and rapid deterioration. The son verbalized understanding and wished to continue his mother's full code status.			

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	During an interview on 1/8/24 at 2:03 P.M., the APS Special Investigator indicated, on 1/3/24 at 3:04 P.M., she was informed by the SSD (Social Service Director) at the facility they wanted a care plan meeting with Resident F's son, who was her Power of Attorney, due to the facility's concern the resident needed to be placed in hospice care and was not eating. At 3:17 P.M., the SSD asked APS person to make arrangements for the care meeting as the son was difficult with the SSD. At 3:45 P.M., the APS person called the son and the meeting was scheduled for 1/8/24 at 10:00 A.M. Then, at 3:52 P.M., the son called back to APS stating the DON called him and wanted to know if they should resuscitate his mother. At 4:20 P.M., she called the SSD and told her the son wanted to have his mother sent to the ER, SSD asked her to hold and at 4:32 P.M., stated the resident would be sent to ER and would be there in about an hour. The APS person told the son to contact the hospital to check, on his mom in about an hour. At 6:00 P.M. she contacted the facility, as the son had called to tell APS person his mother never arrived to the hospital. The APS person talked to LPN 2 on the unit, and he was unaware he was to send the resident to the hospital, but indicated he would send her out to the ER. During an interview on 1/8/24 at 3:42 P.M., LPN 2 indicated he was told to send the Resident F to the ER around 5:45 P.M. by LPN 3, and that it was not an emergency to do so, as it was a request of the family. Then around 6:00 P.M., he received a call from a lady stating she was from APS and asking why the resident was still at the facility, when the son had requested she be sent to the emergency room. LPN 2 indicated the son came to the facility just prior to APS calling. He indicated he had worked a 12 hour shift and had been the resident's nurse all day. He indicated he had let			

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	the DON know that morning the resident had a change of condition, as she had declined since the previous day when he took care of her. He indicated no one had directed him to send her to the ER until later that evening. He had checked the resident's vital signs in the morning and just prior to her release to the hospital. During an interview on 1/8/24 at 3:47 P.M., the NP indicated he had observed the resident on the afternoon of 1/3/24. She wasn't doing well, very poorly, but did not give an order to send the resident to the ER. He indicated staff had informed him they were trying to get the son to agree to a no code status. During an interview on 1/8/24 at 4:10 P.M., the DON indicated she and the NP had discussed calling the son to inform him of his mother's condition, because they thought she was approaching death. She had contacted the son and had asked the son if he wanted them to proceed with a full code states, as the resident wouldn't probably "make it" until the care plan meeting. The DON indicated the son hung up on her. She confirmed she had not spoken to the son until 4:30 PM per the change of condition form and the notification of the NP was in the AM, but the order to send the resident to the ER was not given until later that day. On 1/9/24 at 1:42 P.M., the Administrator provided a policy titled, "Acute Condition Changes - Clinical Protocol", dated March 2018 and indicated the policy was the one currently used by the facility. The policy indicated "...Cause Identification 1. The staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, medication regimen,			

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	and diagnostic test results. a. If necessary, the physician will order diagnostic tests and evaluate the patient directly. 2. As needed, the physician will discuss with the staff and resident/patient and/or family the pros and cons of diagnosing and managing the situation in the facility or the need for hospitalization...Treatment/Management 1. The physician will help identify and authorize appropriate treatments. 2. The physician and staff will identify relevant resident/patient wishes, including advance directives...3. If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital, Emergency Room, or another appropriate setting...." This citation relates to Complaint IN00425453. 3.1-37(a)			