STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT WAYNE, IN 46804

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00398685 and IN00398772. Complaint IN00398685 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F773, and F777. Complaint IN00398772 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 19 and 20, 2023 Facility number: 000476 Provider number: 155446 AIM number: 100290870 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 11 Medicaid: 67 Other: 4 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 25, 2023	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests a Post Survey Desk Review.	
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			

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

David Holbrook | Executive Director | 01/30/2023

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

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	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 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			

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	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 notify the family of a significant change in condition for 1 of 3 residents reviewed (Resident B). Findings include: On 1/19/23 at 12:25 P.M., Resident B's family member was interviewed. The family member indicated concerns with the resident's decline. The decline occurred while the family member was out of town. She was notified on 11/21/22, the resident had declined and was a candidate for hospice services. She came to the facility on 11/22/22 and observed the resident appeared dehydrated with a dry, cracked tongue. She was told the resident was no longer walking, talking, eating or drinking well, had been diagnosed with a urinary tract infection (UTI) and had been given a course of antibiotics. The family member indicated prior to her short absence, the resident had been able to walk and feed herself. She was never notified the resident had declined or had a UTI until she received the phone call from the facility asking if she wanted the resident on hospice services for end of life care. The family member requested the resident be sent to the hospital for treatment due to not eating or drinking. While hospitalized, the resident was diagnosed with metastatic cancer and passed away. On 1/19/23 at 11:45 A.M., Resident B's record was reviewed. Diagnoses included dementia, chronic obstructive pulmonary disease, and heart failure.	F 0580	F-580 1. The facility is unable to correct the alleged deficient practice for Resident B as she no longer resides in the facility. 2. All residents who have a change in condition have the potential to be affected by the alleged deficient practice. An audit of all residents was performed by DNS/designee to ensure no other residents have a change in condition and if noted ensuring that family was notified. 3. Change in Condition policy reviewed with no changes needed. All Care Team Members have been educated on policy and completion of E-Interact change in condition by DNS/designee. 4. DNS/Designee will review each business day in clinical meeting to ensure completion of change in condition and family notification. Daily X6 weeks, then 3X week X6 weeks, then weekly X12 weeks. Results will be reviewed at each QA meeting for compliance	02/03/2023

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A significant change MDS (Minimum Data Set) assessment, dated 11/15/22, indicated the resident had severely impaired cognition. She had significant changes in her activities of daily living (ADL). This included the need for increased assistance to 2 staff members for transfers and toileting. Prior to the significant change, she had ambulated independently with staff supervision but was no longer able to walk, was always incontinent of bladder, and had a significant change in her weight over the past 9 months.

Review of progress notes indicated the following:

-11/9/22 at 1:57 a.m., the resident appeared to be declining. She wanted to stay in bed, was requiring maximum assistance to get into the wheelchair and appeared to be in pain at times.
-11/9/22 at 2:00 p.m., the IDT (Interdisciplinary team) reviewed the resident due to a decline in her ADL's and physical condition. She required increased assistance in mobility, transfers, eating, and mobility. The resident was now using a wheelchair due to unsteadiness and she was not eating or drinking. The nurse practitioner (NP) and family were to be notified of the change.
-11/21/222 at 12:52 p.m., the Social Service Director (SSD) spoke with the resident's family member about her being a candidate for hospice services. The family member indicated she would be in the following day to speak with staff.

Progress notes did not indicate the resident's family member had been notified of the change in condition prior to 11/21/22, 12 days after the IDT had discussed the change.

On 1/19/23 at 3:32 P.M., the SSD was interviewed. She indicated a discussion had been held during a

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	morning meeting to review the decline in the resident's condition. She indicated had been asked by the previous Administrator and Director of Nursing Services to contact the family and inquire about hospice services. The SSD indicated she wasn't aware nursing staff hadn't told the family about the decline in Resident B's condition. She indicated the family had been surprised and upset they hadn't been told of the resident's deteriorating condition. The family should have been notified of her condition prior to being asked about end of life services/hospice care. On 1/20/22 at 11:17 A.M., a current facility policy, titled "Notification of Changes" provided by the Consultant Nurse, stated the following: "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician and notified consistent with his or her authority, the resident's representative when there is a change requiring notification...Circumstances requiring notification include...2. significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions or b. Clinical complications...." This Federal tag relates to IN00398685. 3.1-5(a)(2)			
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.			

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	(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to obtain physician ordered laboratory tests for 2 of 3 residents reviewed (Resident B and Resident D). Findings include: 1. On 1/19/23 at 11:45 A.M., Resident B's record was reviewed. Diagnoses included dementia, chronic obstructive pulmonary disease, and heart failure. She'd had a recent decline in condition which led to hospitalization, diagnosis of metastatic cancer and death. A physician order, dated 11/22/22, was to obtain a complete blood count (CBC) with differential and comprehensive metabolic panel (CMP) one time a day. Progress notes indicated the following: -11/22/22 at 12:53 p.m., the resident's family had concerns regarding hydration, believed the resident was dehydrated and had concerns about use of diuretics. The Nurse Practitioner (NP) was notified and lab orders obtained for a CBC with differential and CMP to be done in the morning. CNA's (Certified Nurse Assistants) were instructed to offer fluids/water frequently and clean/moisten the resident's mouth and tongue with toothettes. -11/23/22 at 2:48 p.m., the NP saw the resident due	F 0773	F-773 1. The facility is unable to correct the alleged deficient practice for Res B as she no longer resides in the facility 2. All residents who have labs ordered have the potential to be affected. An audit of all residents who have labs ordered was completed to ensure all current labs were completed as ordered. 3. Lab/Diagnostic policy reviewed. All Care Team members educated on policy by DNS/designee. Audit will be completed each business day in clinical meeting to ensure completion of labs. 4. DNS/Designee will review each business day in clinical meeting to ensure completion of labs that were ordered; daily X6 weeks, then 3Xweek X6 weeks, then weekly X12 weeks. Results will be reviewed at each QA meeting for compliance.	02/03/2023

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	to her family member's concern that she was "off" compared to her baseline and could have a urinary tract infection (UTI) due to history of. An order had been previously placed for a UA (urinalysis), CBC with diff, and CMP for the morning collection on 11/23/22, but the nurse denied knowing if the labs had been collected. The orders for the CBC with diff and CMP would be changed to STAT and nursing was to collect the UA if not already collected. The resident was prescribed a diuretic due to heart failure but had no edema. Her mouth was dry and blood pressure was in the low 100's. Orders were given to hold the diuretic if the resident's systolic (top number) blood pressure was less than 120. -11/25/22 at 5:53 a.m., the resident was declining and she hadn't wanted to eat or drink anything. There was no indication in the notes the ordered labs had been obtained. -11/25/22 at 2:41 p.m., the resident's family member requested the resident be sent to the hospital due to her decline in condition. Orders were obtained and the resident was transferred to the hospital. Review of the resident's record didn't indicate the labs for a CBC with diff, CMP, or UA had been completed as ordered. 2. On 1/19/23 at 3:50 P.M., Resident D's record was reviewed. Diagnoses included dementia and left hip pain. An NP progress note, dated 11/8/22 at 2:50 p.m., indicated the resident had been seen for left hip pain. Per nursing, she had a history of falls and left hip pain for several weeks. She'd had no known recent injuries or falls. Her left hip and groin was observed to be reddened with pain			

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	when touched. She was observed wearing an incontinent brief with redness around the brief line on the left side of her body. She had no fever. She was given Tylenol for pain. The medication wasn't effective. The plan was to obtain an x-ray of her left hip, obtain labs for a CBC and BMP (Basic Metabolic Profile), and start short term pain management with an opioid for 10 days. A physician order, dated 11/8/22, was to obtain a CBC and BMP once for left hip redness. Resident D's record had no results for the lab work ordered on 11/8/22 nor follow up documentation to indicate why the labs had not been completed. On 1/20/23 at 11:17 A.M., the Nurse Consultant was interviewed. She indicated she was not aware why the labs for Resident B or Resident D had not been completed as ordered due to her recent employment with the company. The facility had no policy for lab procedures but labs, including those ordered for Resident B and Resident D, should be obtained when ordered by the physician or NP and reported promptly upon receipt of results. This Federal tag relates to Complaint IN00398685. 3.1-49(a)			
F 0777 SS=D Bldg. 00	483.50(b)(2)(i)(ii) Radiology/Diag Srvcs Ordered/Notify Results §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope			

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	of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to obtain physician ordered x-rays for 1 of 2 residents reviewed (Resident D). Findings include: On 1/19/23 at 3:50 P.M., Resident D's record was reviewed. Diagnoses included dementia and left hip pain. An NP progress note, dated 11/8/22 at 2:50 p.m., indicated the resident had been seen for left hip pain. Per nursing, she had a history of falls and left hip pain for several weeks. She'd had no known recent injuries or falls. Her left hip and groin was observed to be reddened with pain when touched. She was observed wearing an incontinent brief with redness around the brief line on the left side of her body. She had no fever. She was given Tylenol for pain The medication hadn't been effective. The plan was to obtain an x-ray of her left hip, obtain labs for a CBC and BMP (Basic Metabolic Profile), and start short term pain management with an opioid for 10 days. An NP progress note, dated 11/22/22 at 1:52 p.m., indicated the resident was seen for left hip pain. She had recently been evaluated for left hip pain on 11/8/22 and an x-ray completed on 11/11/22, showed no acute findings. She was assessed and reported pain in her buttock/tailbone area. There was no redness, protrusion, or pain when	F 0777	F-777 1. The facility is unable to correct the alleged deficient practice for Res D as she no longer resides in the facility 2. All residents who have labs ordered have the potential to be affected. An audit of all residents who have diagnostics ordered was completed to ensure all current diagnostics were completed as ordered. 3. Lab/Diagnostic policy reviewed. All Care Team members educated on policy by DNS/designee. Audit will be completed each business day in clinical meeting to ensure completion of diagnostics. 4. DNS/Designee will review each business day in clinical meeting to ensure completion of diagnostic tests ordered; daily X6 weeks, then 3X per week X6 weeks, then weekly X12 weeks. Results will be reviewed at each QA meeting for compliance.	02/03/2023

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	touched. The resident had complained of some nausea and a short term trial of anti-nausea medication was prescribed. The order for opioid pain medication had expired and she had Tylenol available as needed for pain. An NP progress note, dated 11/23/22 at 2:26 p.m., indicated the resident was seen for continued left hip pain. She continued to report pain overnight and was currently having pain. She had an x-ray of the left hip completed on 11/11/22 with no acute findings. A repeat x-ray was to be obtained and the opioid pain medication restarted routinely until imaging was obtained. The resident was observed lying on her right side during the visit, with her eyes closed and yelling out with pain in her left hip. A physician order, dated 11/23/22, was to obtain a pelvic and left hip x-ray for pain. The resident's record hadn't indicated the pelvic and left hip x-ray had been obtained as ordered. The resident passed away on 11/27/22 without the ordered x-rays completed. On 1/20/23 at 11:17 A.M., the Nurse Consultant was interviewed. She indicated she was not aware why the x-rays for Resident D had not been completed as ordered due to her recent employment with the company. The facility had no policy for x-rays but indicated x-rays should be obtained as ordered per the physician or NP and results reported promptly. This Federal tag relates to Complaint IN00398685. 3.1-49(j)(1)			