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	06/09/2023

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

(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 Complaint IN00409786, IN00409277 and IN00410244. Complaint IN00409786- Federal/state deficiencies related to the allegations are cited at F578 and F695. Complaint IN00409277 - No deficiencies related to the allegations are cited. Complaint IN00410244 - No deficiencies related to the allegations are cited. Survey dates: June 8 and 9, 2023. Facility number: 000476 Provider number: 155446 AIM number: 100290870 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 6 Medicaid: 69 Other: 12 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 12, 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 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Blackburn	RN, Regional Nurse Consultant	06/22/2023

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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	§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in			

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	place to provide the information to the individual directly at the appropriate time. Based on interview and record review the facility failed to ensure code status was indicated on the resident's profile page for 1 of 5 residents reviewed (Resident B). Findings include: In an interview on 6/9/23 at 11:49 AM, Licensed Practicial Nurse (LPN) 3 indicated Resident B was unresponsive on 5/13/23. LPN 3 reviewed Resident B's profile page on her chart and the code status was blank. LPN 3 indicated she instructed Certified Nurse Aide (CNA) 2 to call Resident B's family to confirm code status. In an interview on 6/8/23 at 9:41 AM, Resident B's family indicated CNA 2 called and requested Resident B's code status as she was unresponsive. Resident B's record was reviewed on 6/8/23 at 3 PM. Diagnoses included: chronic respiratory failure and tracheotomy status. An order, dated 5/2/23 - 5/8/23, indicated Resident B's code status was full code. There were no active order for code status. Resident B's profile page following the code status section was blank. Statements were provided by the Regional Consultant on 6/9/23 at 1:45 PM. The statements indicated the following: CNA 5's statement indicated on 5/13/23 she called the family to confirm Resident B's code status.	F 0578	1. What corrective action(s) will be accomplished for those residents found to have ben affected by the alleged deficient practice. The facility is unable to correct the alleged deficient practice for resident in question as resident no longer resides at the facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. A whole house audit was completed on all residents to ensure code status was entered into PCC and POST form completed and matched. 3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. In-house admissions will try to get code status before resident admits and then staff will follow up with a POST form. If admissions are unable to obtain code status before admission, then floor nurse will need to get code status. DNS/Designee will audit all new admission to ensure that code status is entered into PCC, POST	06/23/2023

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	LPN 3's statement indicated CNA 2 called the family and requested code status as no one could find the code status in Resident B's chart. CNA 2's statement indicated "no one knew if Resident B was a full code." In an interview on 6/9/23 at 12:01 PM, the Regional Consultant indicated the code status should be listed in the resident's profile page and orders. This Federal Finding relates to Complaint IN00409786. 3.1(4)(f)(5)		form is completed and matches. Nurse Consultant will audit weekly for completion. Nurses educated by DNS/Designee to ensure they are entering a code status for all new admissions. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie,. what quality assurance program will be put into place. Audits will be performed daily to ensure code status is in PCC for all new admissions for 6 months and then QA committee will adjust audits accordingly. Results of audits will be discussed at monthly Quality Assurance meetings. If 100% threshold is not met, then an action plan will be developed. The QA Committee will adjust audits based on findings.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review the facility failed to ensure tracheostomy care was performed	F 0695	1. What corrective action(s) will be accomplished for those	06/23/2023

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	for 1 of 2 residents reviewed (Resident B). Findings include: In an interview on 6/8/23 at 9:41 AM, Resident B's family indicated tracheostomy care was not performed as ordered. Resident B's family indicated on 5/13/23 Certified Nurse Aide (CNA) 2 called and notified the family Resident B fell and her trach tube fell out. In an interview on 6/9/23 at 11:49 AM, Licensed Practical Nurse (LPN) 3 indicated on 5/13/23 she was paged STAT to the unit as Resident B fell and her trach tube fell out. LPN 3 indicated she instructed CNA 2 and 4 to get the crash cart and call 911. LPN 3 indicated the CNAs and Qualified Medication Aide (QMA)s indicated they couldn't find spare trach tubes or an ambu bag in the crash cart or at bedside. LPN 3 indicated she performed (CPR) cardiopulmonary resuscitation until Emergency Medical Services (EMS) arrived. LPN 3 indicated every resident with a tracheostomy should have a trach tube, ambu bag and suction machine at bedside in case of an emergency. LPN 3 indicated there should have been extra supplies in the crash cart and the medication room. LPN 3 indicated the nurses should have checked to ensure the extra supplies were at bedside. Statements were provided by the Regional Consultant on 6/9/23 at 1:45 PM. The statements indicated the following: LPN 3's statement indicated she was paged overhead to return to the unit. LPN 3 entered Resident B's room and saw her on the floor with her trach tube dislodged on the floor. LPN 3 indicated she told the CNAs to look in Resident B's drawer for an extra trach tube. The CNAs		residents found to have been affected by the deficient practice. The facility is unable to correct the alleged deficient practice for resident as resident no longer resides in the facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents with a tracheostomy in the facility have the potential to be affected by the alleged deficient practice. An audit of all residents with a tracheostomy was completed to ensure there was an ambu bag and extra inner cannula at beside. A review of all tracheostomy residents was completed t ensure that there are orders in the electronic MAR to monitor the tracheostomy tube every shift, to monitor the tracheostomy site every shift, keep a spare inner cannula/trach at bedside, change the inner cannula with trach care and to cleanse the trachea siet. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. DNS/Designee will audit any trach residents each business day to ensure extra trach at bedside, ambu bag at bedside, orders are signed off in MAR and observe	

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	indicated they could not find it. LPN 3 instructed CNA 4 to call 911 and LPN 3 placed oxygen over Resident B's neck stoma. LPN 3 indicated CNA 2 notified the family and once the resident became unresponsive LPN 3 performed CPR until the EMS arrived. CNA 2's statement indicated CNA 4 yelled for CNA 2's assistance as Resident B was on the floor. CNA 2 indicated she paged LPN 3 overhead. CNA 2 indicated LPN 3, CNA 6 and CNA 5 arrived to the room and CNA 6 tried to put Resident B's tracheostomy back in. CNA 2 called 911 and LPN 3 started CPR on Resident B. CNA 4's statement indicated she answered Resident B's call light. Resident B was observed to be on the floor at the end of her bed and her trachea was out. CNA 4 yelled to CNA 2 for assistance. LPN 3 arrived with an aide and QMA then CNA 4 exited the room. CNA 6's statement indicated she responded to the STAT overhead page. CNA 6 indicated when she got to Resident B's room, the resident was on the floor unresponsive with her trach tube out. CNA 6 indicated she went to get the crash cart and tried to look for what LPN 3 requested. CNA 6 indicated she also tried to put the trach tube back into Resident B's throat. CNA 5's statement indicated she responded to the STAT overhead page. CNA 5 indicated when she arrived, Resident B was on the floor unresponsive with her trach tube out. LPN 3 instructed CNA 5 to call the family. In an interview on 6/9/23 at 1:04 PM, QMA 9 indicated she did not know where extra trachea supplies were located.		trach care 3X's a week. Nursing staff educated to ensure extra trach and ambu bag at bedside, to perform trach care and sign off in MAR and that nurses are only ones to provide any trach care by DNS/Designee. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place. Audits will be performed each business day on any trach residents to ensure extra trach at bedside, ambu bag at bedside, orders signed off in MAR and observe trach care 3 X's weekly. Audit will be completed each business day for 3 months, then 3 X's a week for 3 months, then weekly for 3 months. Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA committee will adjust audits based on findings.	

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	In an interview on 6/9/23 at 1:07 PM, QMA 10 indicated extra trachea supplies would be in the medication room and would go to another hall if needed. QMA 10 indicated she did not know what an ambu bag looked like. In an interview on 6/8/23 at 10:51 AM, LPN 7 indicated extra trachea supplies are located at bedside, in the crash cart or medication room. Resident B's record was reviewed on 6/8/23 at 3 PM. Diagnoses included: chronic respiratory failure and tracheostomy status. A nursing note, dated 5/13/23, indicated LPN 3 was notified by staff that Resident B fell and her tracheostomy tube dislodged. The note indicated LPN 3 told the CNA to get another inner cannula/trachea tube and the CNA indicated "there was none in the drawer." LPN 3 instructed staff to call 911. LPN 3 indicated she performed (CPR) cardiopulmonary resuscitation as the resident stopped breathing. The Medication Administration Record (MAR) dated 4/1/23 -5/14/23 was reviewed: An order, dated 5/2/23 - 5/8/23, indicated to keep an ambu bag at bedside every shift. The MAR indicated no documentation regarding the ambu bag being at bedside on the following daates and shifts: 1st shift: 4/19/23, 4/20/23, 4/23/23, 4/28/23, 5/3/23, 5/5/23 2nd shift: 4/15/23, 4/16/23, 4/17/23, 4/21/23, 4/27/23, 5/4/23 3rd shift: 4/13/23, 4/19/23, 4/24/23, 4/26/23, 5/4/23			

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	An order, dated 5/3/23 - 5/8/23, indicated to monitor the tracheostomy tube for placements and function every shift. The MAR indicated no documentation regarding the tracheostomy tube on the following dates and shifts: 1st shift: 4/19,23, 4/20/23, 4/23/23, 4/27/23, 4/28/23, 5/5/23 2nd shift: 4/15/23, 4/16/23, 4/17/23, 4/21/23, 4/27/23, 5/4/23 3rd shift: 4/13/23, 4/19/23, 4/24/23 4/26/23, 5/4/23 An order, dated 4/4/23 -5/1/23 and 5/2/23-5/8/23, indicated to monitor the tracheostomy site for signs and symptoms of infection. The MAR indicated no documentation regarding signs and symptoms of infection on the following dates and shifts: 1st shift: 4/19/23, 4/23/23, 4/28/23, 5/3/23 2nd shift: 4/15/23, 4/16/23, 4/17/23, 4/21/23, 4/27/23, 5/4/23 3rd shift: 4/13/23, 4/19/23, 4/22/23, 4/24/23, 4/26/23, 5/4/23, 5/5/23 An order, dated 4/4/23 -5/1/23 and 5/2/23 - 5/8/23, indicated to keep a spare tracheal tube of the same size and smaller at bedside every shift. The MAR indicated no documentation regarding the availablility of a tracheal tube on the following dates and shifts: 1st shift: 4/19/23, 4/20/23, 4/23/23, 4/28/23, 5/3/23, 5/5/23 2nd shift: 4/15/23, 4/16/23, 4/17/23, 4/21/23, 4/27/23, 5/4/23 3rd shift: 4/13/23, 4/19/23, 4/26/23, 5/4/23 An order, dated 4/4/23 -5/1/23, indicated to change the disposable inner cannula with trach			

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	care every 12 hours and as needed. The MAR indicated no documentation regarding changing the inner cannula or trach care on the following dates and shifts: 1st shift: 4/6/23, 4/19/23, 4/20/23, 4/27/23, 4/28/23 3rd shift: 4/4/23, 4/6/23, 4/14/23, 4/15/23, 4/16/23, 4/17/23, 4/18/23, 4/21/23, 4/22/23, 4/27/23 An order, dated 4/4/23 -5/1/23 and 5/2/23 - 5/8/23, indicated to cleanse trachea stoma site with normal saline twice daily and as needed. The MAR indicated no documentation regarding cleansing the stoma site on the following dates and times: 1st shift: 4/6/23, 4/11/23, 4/19/23, 4/20/23, 4/23/23, 4/27/23, 4/28/23, 5/3/23, 5/5/23 2nd shift: 4/15/23, 4/16/23, 4/17/23, 4/21/23, 4/27/23, 5/4/23 There were no active tracheostomy orders for 5/13/23. A current policy, undated, titled "Tracheostomy Care" was provided by the Regional Consultant on 6/8/23 at 9:40 AM. The policy indicated tracheostomy care should be provided per physician orders...general considerations are: tracheostomy provided at least twice daily and to maintain supplies easily accessible for immediate emergency care. These supplies included: "suction machine, a supply of suction catheters, correctly sized cannulas, and an ambu bag." This Federal Finding relates to Complaint IN00409786. 3.1-47(a)(4)(6)			