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	08/28/2023

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 Recertification and State Licensure Survey and the investigation of Complaints IN00414945, IN00414477, IN00412401, IN00409697 and IN00409479 This visit was in conjunction with the Investigation of Complaints IN00415753 and IN00415686. Complaint - IN00414945 - No deficiencies related to the allegations are cited Complaint - IN00414477 - No deficiencies related to the allegations are cited. Complaint - IN00412401 - Federal/state deficiencies related to the allegations are cited at F921. Complaint - IN00409697 - No deficiencies related to the allegations are cited. Complaint - IN00409479 - Federal/state deficiencies related to the allegations are cited at F600 and F755. Complaint - IN00415753 - No deficiencies related to the allegations are cited. Complaint - IN00415686 - Federal/state deficiencies related to the allegations are cited at F600. Survey dates: August 20, 21, 22, 23, 24, 25, 26, 27 & 28, 2023 Facility number: 000124	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Blackburn	RN, Regional Nurse Consultant	09/30/2023

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.

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	08/28/2023

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
	Provider number: 155219 AIM number: 100266730 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 7 Medicaid: 73 Other: 8 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review conducted 9/14/2023.			
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the			

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	08/28/2023

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
	facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on observation, record review and interviews, the facility failed to ensure 28 residents with resident trust accounts had access to more than $50.00 of their funds on a daily basis and had reasonable access after hours and on weekends. Finding includes: During an interview with alert and oriented, Resident 15, on 8/22/2023 at 11:34 A.M., she indicated she could not access her resident fund money after 5:00 P.M.on Fridays. During an interview with alert and oriented, Resident 41, on 8/21/2023 at 2:09 P.M., he indicated resident fund money was only available if the Business Office Manager was in the building.	F 0567	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **Upon notification from surveyor, the BOM posted facility banking hours on 8-25-23 at the front desk.** **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 have the potential to be affected by the alleged deficient practice. BOM has reviewed all	09/30/2023

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	08/28/2023

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 a review of the resident trust accounts and interview with the Business Office Manager, on 8/25/2023 at 9:30 A.M., she indicated residents only had access to $50.00 of their resident funds per day during the front receptionist hours. The Business Office Manager indicated $50.00 was the daily limit per the company policy. She indicated there was no system to allow residents to access more than $50.00 per day. On the weekend, the facility had recently started maintaining $50.00 of resident fund monies in a bag kept on the North unit's nurses cart. The $50.00 was the total amount maintained on the weekend and there was no system to obtain more monies should the $50.00 run out on the weekend. Prior to the $50.00 being kept on the North unit nurse's cart, the residents could only access their monies during the weekend receptionist hours of 9:00 A.M. - 3:00 P.M. The Resident Trust Fund information, provided in the Resident Admission information did not contain any specific information regarding withdrawing monies, any limitations to daily money withdrawals or any hours of service or after hours instructions for obtaining Resident trust fund monies. There was no Resident Trust Fund signage located near the receptionist desk, front lobby or on the Business Office Manager's office door notifying residents of hours and/or limitations for Resident Trust Fund withdrawals. Review of the Facility's current policy and procedure, titled, "RFMS Policy and Procedure," provided by the Regional Nurse Consultant on 8/26/2023 at 11:58 A.M., included the following: "...Residents can withdrawal cash for an amount		residents who should have access to resident funds and those residents notified of availability to access funds. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** BOM in-serviced by Nurse Consultant on 9-26-23 on residents having access to resident trust funds on a daily basis and reasonable access after-hours and on weekends. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED/Designee will audit 5 residents weekly X6 months to ensure they have access to resident trust funds. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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	08/28/2023

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
	up to $50.00 a day. If a request is made for an amount over $50.00 if (sic) will be in the form of a check and will be available to the Resident within 3 days of request...." The policies mentioned the facility petty cash account to cover resident fund account withdrawal requests but did not disclose any hours of service, limitations other than $50.00, or location of the petty cash after hours and on weekends. 3.1-6(f)(1)			
F 0569 SS=D Bldg. 00	483.10(f)(10)(iv)(v) Notice and Conveyance of Personal Funds §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. Based on record review and interview, the facility failed to ensure there was documentation 1 of 28 residents with a resident trust account exceeding	F 0569	**1 What corrective actions(s) will be accomplished for those residents found to have been**	09/30/2023

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	08/28/2023

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
	the Medicaid allowable limit was notified of the regulation. (Resident 71) Finding includes: During a review of the facility Resident Trust Accounts, on 8/25/2023 at 9:30 A.M., with the Business Office Manager, she disclosed Resident 71, a Medicaid funded resident's Resident Trust Account exceeded the allowable Medicaid limit. Review of the account ledger for Resident 71's Resident Trust Account, the resident had $4, 614.73 on 5/30/2023. The resident's current account balance, on 8/16/2023, was $3, 404.95. During an interview with the Business Office Manager, on 8/25/2023 at 9:30 A.M., she indicated she had verbally spoken with Resident 71 regarding her account balance. There was no documentation regarding the conversation, the Business Office Manager was unable to give a date she had spoken with the resident and although the resident's trust fund account balance was lower, it still exceeded the Medicaid limitation. 3.1-6(h)		**affected by the deficient practice:** Resident #71 has spent her money and is below the Medicaid allowable limit. **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 have resident trust funds that exceed the Medicaid allowable limit have the potential to be affected by the alleged deficient practice. The BOM reviewed all trust funds on 9-28-23 to ensure residents trust account does not exceed the Medicaid allowable limit. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** BOM in-serviced by Nurse Consultant on 9-26-23 on the Medicaid allowable limit and documenting conversations with residents. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED/Designee will audit 5 residents	

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	08/28/2023

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
			weekly X6 months to ensure there are not any residents exceeding the Medicaid allowable limit and if they are that there is documentation that resident has been made aware. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents interviewed were free of verbal abuse. (Resident E) Finding includes: On 8/23/23 at 10:22 A.M., a review of the clinical	F 0600	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E verbalized she feels safe when interviewed by Social Services on 9-29-23 and continues to reside in the facility.	09/30/2023

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	08/28/2023

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
	record for Resident E was conducted. The resident's diagnoses included, but was not limited to: End Stage Renal Disease (ESRD), heart failure, diabetic, dependent on dialysis, respiratory failure-dependent on supplemental oxygen and morbid obesity. A Progress Note, dated 8/5/23 at 2:46 P.M., written by RN 5 indicated the resident had a behavior that morning. The Note indicated the resident had waited awhile for CNA 6 and when she arrived, to the room, the resident had taken her own brief off and had thrown it on the floor. RN 5 talked to the resident concerning her behavior with CNA 6. A Progress Note, dated 8/9/2023 at 2:08 P.M., indicated the Interdisciplinary Team (IDT) met with Resident E's sister regarding the incident on 8/5/23. The sister was informed the incident was reported to the Indiana Department of Health and CNA 6 was suspended pending an investigation. A Facility self-reported incident #321 indicated on 8/6/23 at 2:46 PM, " ...resident reported today 8/7/23 to staff that another staff yelled at her during care yesterday ...." CNA 6 was suspended pending investigation. The follow-up, dated 8/14/23, indicated " ...Facility completed investigation and was unable to collaborate Resident's claim. Education provided to staff. Social Service and psych to continue to follow up with Resident as needed ...." A statement from CNA 6, dated 8/14/23, indicated she had went into the Resident E's room around 8:30 A.M. to care for the resident and asked if she was ready to get up. The resident told her it was to early, so she moved on to check on others. When she later walked back into resident's room. CNA indicated both residents in the room		**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 have the potential to be affected by the alleged deficient practice. Other residents were interviewed by DNS/Designee on 8-8-23 with no concerns voiced. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **Staff educated on Abuse policy by DNS/Designee on** 9-29-23. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **ED/Designee will audit/interview 5 residents weekly X6 months to ensure there are no concerns voiced. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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
	shouted at her for not answering the call light sooner. The statement indicated she went to the resident who needed help, she had her brief off, stool on her gown and her bed linen had been thrown on the floor. CNA 6 apologized to her for not getting there faster but the problem proceeded to escalate, so she went out of the room and found RN 5. RN 5 went to Resident E's room to de-escalate the situation. A statement from roommate, dated 8/7/23, indicated she heard staff yelling at roommate-Resident E. A statement from RN 5, dated 8/10/23, indicated the aide, assigned to resident, came to get her, indicating the resident was having a behavior. Resident E told RN 5 she had to wait for a while before she could get cleaned up. CNA 6 told RN 5 she was attending other residents. RN 5 stated "...Behavior manifested by the resident included taking her dirty brief and throwing it on the floor and had all other trash scattered all over the floor...." Statement indicated RN 5 talked with resident about the "...unacceptable behavior and the aide cleaned the resident up and the room....." A Care Team Member Corrective Action Form, indicated Resident E reported, allegation of abuse, which occurred on 8/6/23, by CNA 6. This was her first corrective action. The form indicated she would return to work but will not be on the team to take care of resident again. During an interview, on 8/22/23 at 11:06 A.M., Resident E indicated approximately 2 weeks ago when she had diarrhea, the girls who cleaned her up weren't nice. She had tried to clean herself up and they were upset with her and raised their voices at her. It made her feel bad.			

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	08/28/2023

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 8/22/23 at 11:21 A.M., Resident K indicated she witnessed the whole incident and called Resident E's sister. RN 5 and CNA 6 were yelling at Resident E, telling her she made a mess. Resident K indicated the CNA is no longer to provide care for either of them.

During an interview, on 8/24/23 at 3:19 P.M., Resident E's sister heard the a staff member yelling at Resident E. She came to the facility, the next day, to talk to the Administrator, but he was out of town. The sister indicated Resident E had diarrhea and had her light on for a couple hours, so the Resident E took the brief off herself. The resident's sister thought there were 2 voices but wasn't sure but could hear yelling from the Resident's Roommate's phone on other side of the room.

On 8/23/23 at 10:25 A.M., the Regional Nurse Consultant provided a policy titled, "Abuse Prevention Program", dated 2/2018 and revised on 3/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...Abuse - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted

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	08/28/2023

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
	deliberately, no that the individual must have intended to inflict injury or harm...." This Federal tag relates to complaint IN00409479 and IN00415686. 3.1-27(a)(b)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;			

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	08/28/2023

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
	(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,			

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	08/28/2023

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
	codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure that notification of the Ombudsman was made in a timely manner of resident's discharge from the facility for 1 of 1 resident reviewed for notification of discharge. (Resident 86) Finding includes:	F 0623	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **The facility social worker notified the Ombudsman of transfer of Resident #86 on 9-29-23.** **2 How other residents**	09/30/2023

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	08/28/2023

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 clinical record review was completed on, 8/23/2023 3:17 P.M., diagnoses for Resident 86 included, but were not limited to: systemic lupus erythematosus, Human Immunodeficiency Virus, bipolar disorder manic with psychotic features, anxiety disorder, schizoaffective disorder. An MDS (Minimum Data Set) assessment was initiated on 6/16/2023 and not completed. Resident 86 was admitted 6/16/2023 and sent to the hospital on 6/17/2023. Resident 86 returned to facility 6/20/2023 and sent to the hospital on 6/21/2023 with discharge not anticipated. A Progress Note, dated 6/17/2023 at 9:21 P.M., indicated "...stated that she is hearing voices in her mind and was put on fifteen minutes checks...." A Progress Note, dated 6/17/2023 at 9:30 P.M., indicated "...trying to put a cord round her neck, put on 1:1 with staff. At 10:00 P.M., Resident call 911 stating that she want to hurt self-using a cord. 911 staff arrived took her to Saint Joe Hospital...." A Progress Note, dated 6/21/2023 at 3:46 P.M., indicated that "...Admissions director, in meeting with resident 86, attempting to drink soap, eat deodorant, and attempted to stab herself with herself with a pen. Resident was yelling when this writer got to the nursing station. Resident reports staff do not treat her well, she is going through a lot, she does not want to be in the building, and does not feel well. Resident reports "I want to hurt myself." SS explained to resident this writer completed assessment this writer explained SS will talk with her if she was not feeling well emotionally and wanting to harm herself. SS explained at this time, due to her being a risk to herself, and other as she was attempting to throw		**having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** **All residents transferred to the hospital have the potential to be affected by the alleged deficient practice. A review of all residents transferred to the hospital in the month of August was conducted on 9-28-23 and Ombudsman notified of these transfers.** **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **Social Service Director in-serviced by Nurse Consultant on 9-28-23 on ombudsman notification monthly and policy and procedure provided.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED/Designee will complete an audit weekly X6 months to ensure that any resident transferred to the hospital is on the monthly notification form to notify the Ombudsman. ED/Designee will ensure that the notification form is sent to Ombudsman at the end of	

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	08/28/2023

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
	things at staff in the hall. Police and EMS arrived, resident still very upset, cursing, and reports no one can sign her in. SS still explaining to resident the law on self-harm. Resident no longer able to redirect. Immediate action, removing resident from her room, and put her in the hall where she could not hurt herself or others. IDT (Interdisciplinary Team) met to discuss and pt. needing psych placement to be regulated on mediation and to stop self-harm. In attendance for the meeting DNS (Director of Nursing Services), UM (Unit Manager), SS (Social Services), MDS (Minimum Data Set)...." A Progress Note, dated 6/22/2023 at 7:30 P.M., indicated "patient sent to the ER" (Emergency Room). A MDS on 6/21/2023 indicated resident was discharged and return not anticipated. During an interview with the Director of Nursing, on 8/23/2023 at 3:15 P.M., indicated the reason for transfer to hospital was related to suicidal ideation. Resident 86 entered facility on 6/16/2023 and was transferred to hospital on 6/17/2023 for suicidal ideation. She returned to the facility on 6/20/2023 per hospital discharge notes and then transferred back to hospital on 6/21/2023 for suicidal ideation. Per IDT (Interdisciplinary Team) determination, Resident 86 needed to be admitted to psych care facility to be placed on medication regimen to help with self-harm attempts. A bed hold was initiated on 6/17/2023 and 6/21/2023 as indicated in record review per Director of Nursing. During an interview, on 8/24/2023 at 3:20 P.M., Social Services indicated no discharge packet was uploaded into the resident's chart and she was unsure of procedure as she is new to position at		each month. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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	08/28/2023

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
	this facility. She attempted to look for ombudsman notification and could not find any email information being sent to the Ombudsman since February 2023. During an interview, on 8/24/2023 at 4:20 P.M., the Regional Nurse indicated when residents are transferred, paperwork is sent with the resident being transferred out and not scanned in chart. During an interview, on 8/25/23 9:44 A.M., the Regional Nurse indicated that the Ombudsman was not notified of Resident 86's transfer. A current policy provided by the Regional Nurse, on 8/25/2023 at 11:15 A.M., indicated " ...Generally, the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because: a). the health and or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b). the resident's health improves sufficiently to allow a more immediate transfer or discharge; c). an immediate transfer or discharge or discharge is required by the resident's urgent medical needs; d). a resident has not resided in the facility for 30 days. In the exceptional cases the notice must be provided to the resident, resident's representative if appropriate, and the LTC (Long Term Care) Ombudsman as soon as practicable before the transfer or discharge. The facility will maintain evidence that the notice was sent to the Ombudsman ...." 3.1-12(a)(6)(A)			

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	08/28/2023

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 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	08/28/2023

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
	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interview, the facility failed to ensure care plans were developed for 1 of 28 residents reviewed. (Resident 11) Finding includes:A record review for Resident 11 was completed on 8/22/2023 at 3:22 P.M. Diagnoses included, but were not limited to: type 2 diabetes, moderate protein-calorie malnutrition, acquired total absence of pancreas, and chronic pain syndrome. During an interview, on 8/20/2023 at 4:37 P.M., Resident 11 was concerned with going blind in his left eye. He was seen by the facility eye doctor and he was told of a cataract in his left eye that needed to be removed. A Quarterly Minimum Data Set (MDS) assessment, dated 11/3/2022, indicated he had impaired vision. A Progress Note, dated 10/31/2022, from the (name of provider)indicated that the patient wants to proceed with surgery. Cataract surgery recommended, ophthalmology consult with follow up in 4-5 months. A Progress Note, dated 4/19/2023, from the (name of provider) indicated patient wanted to proceed	F 0656	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #11's care plan has been updated to reflect impaired vision on 9-28-23 by DNS. Resident 11 assessed by Licensed Nurse on 9-5-23 with no negative findings noted. **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 impaired vision have the potential to be affected by the alleged deficient practice. A review of all residents with impaired vision completed to ensure the impaired vision is care planned by DNS/Designee on 9-29-23.** **3 What measures will be put into place and what systemic changes will be made to**	09/30/2023

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	08/28/2023

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
	with surgery, cataract surgery recommended and ophthalmology consult for left eye. During an interview, on 8/25/2023 at 10:10 A.M., the Director of Nursing indicated that the resident did not have a care plan for his impaired vision and he should have had. On 8/25/2023 at 1:52 P.M., the Regional Nurse Consultant provided a policy titled, "Care Plans-Comprehensive", and indicated the policy was the one currently used by the facility. The policy indicated "...3. Each residents' Comprehensive Care Plan had been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems, c. Build on the resident's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care, f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; and g. Enhance the optimal functioning of the resident by focusing on a rehabilitative program...." 3.1-35(d)(1)(2)(A)		**ensure that the deficient practice does not recur:** **All interdisciplinary care team members responsible for writing care plans in-serviced by DNS on care planning appropriately on 9-29-23.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS/Designee will audit 5 residents weekly X12 weeks, then 3 residents weekly X12 weeks and then one resident weekly X12 weeks. **Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

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	08/28/2023

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
	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview, observation and record review, the facility failed to ensure the care plan was revised and residents were invited to care plan meetings for 1 of 29 residents whose care plans were reviewed. (Resident 26). Finding includes: During an interview, on 8/21/23 9:59 A.M., Resident 26 indicated that he had not been invited routinely or included in care plan meetings. He indicated he was his own representative. During an interview, on 8/25/2023 at 10:01 A.M., with the MDS (Minimum Data Set) nurse, she indicated the Care Plan review "pops up" every quarter with the MDS assessment reminder and both the assessment and care plan were revised at the same time. She indicated the care plan invitations came from the social services department and the new social worker had just	F 0657	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **On 8-28-23 DNS/Designee determined that resident #26 experienced no negative outcomes from deficient practice. Care plan meeting occurred on 9-6-23.** **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 have the potential to be affected by the alleged deficient practice. A review of all residents	09/30/2023

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	08/28/2023

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
	started that week. During an interview, on 8/25/2023 at 2:38 P.M., the Regional Nurse indicated there was no documentation the resident had been invited, notified or included in the care plan meetings. 3.1-35(c)(2)		completed to ensure there has been a care plan meeting scheduled in the last quarter. If not, then an invite has been sent. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **Social Services educated by Nurse Consultant on 9-28-23 on scheduling care plan meetings and including resident.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **ED/Designee will audit 5 residents weekly X12 weeks, then 3 residents weekly X12 weeks, then 1 resident weekly X12 weeks to ensure resident has a care plan meeting scheduled and resident is invited. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by** **the** committee.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable 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	08/28/2023

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
	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observations, record reviews, and interviews, the facility failed to provide shaving for 2 of 3 residents reviewed (Residents 7 and 41) and nail care for 1 of 3 residents reviewed (Resident 41) who were unable to perform these tasks. Findings include: 1. During an observation and interview, on 8/21/2023 at 2:21 P.M., Resident 41 had not been shaved and his fingernails were long with dark brown matter under them. The resident indicated that he would like to be shaved but it is not done, even when he asks. The same problem occurred with his fingernails. A record review, conducted on 8/23/2023 at 11:31 A.M., indicated Resident 41's diagnoses included, but were not limited to: Parkinson's disease and chronic obstructive pulmonary disease. A Quarterly MDS (Minimum Data Set) assessment, dated 7/28/2023, indicated Resident 41 had no cognitive deficits. He required extensive assist of 1 staff for bed mobility, transfers, and toileting. He needed limited assist of 1 for dressing and eating. A Care Plan dated 11/21/2022, reviewed/revised 11/22/2022, included, but was not limited to: needs assistance with activities of daily living with a goal of resident will have care needs met daily with assistance of staff. Interventions included, but were not limited to: assist of 1 for bathing/showering and assist of 1 for personal	F 0677	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #41 was shaved, and fingernails cleaned and cut on 8-28-23. Resident #7 was shaved on 8-28-23. **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 want to be shaved or have dirty fingernails have the potential to be affected by the alleged deficient practice. A review of all residents completed to see if they want shaved or need fingernail care on 9-28-23. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **Nursing Staff educated on shaving residents and cleaning fingernails by DNS/Designee by 9-29-23.** **4 How the corrective action(s) will be monitored to**	09/30/2023

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	08/28/2023

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
	hygiene. Shower sheets for the month of August indicated: 8/2/2023 shaving was done but not nail care 8/5/2023 shaving was done but not nail care 8/9/2023 shaving and nail care were not done 8/12/2023 no shower sheet was present in the record 8/16/2023 the resident refused care 8/19/2023 shaving and nail care were not done During an observation, on 8/24/2023 at 10:27 A.M., the resident indicated he refused a shower the evening before because it was a quarter to 9 and he felt it was too late. He was still unshaved and nails were long with dark brown matter under them. During an observation, on 8/28/2023 at 9:57 A.M., Resident 41 was in bed sleeping, he was unshaved. During an interview, on 8/23/2023 at 2:45 P.M., CNA 6 indicated residents get shaved when they want it done. Resident 41 has never asked to be shaved. CNA 6 asked residents on shower days if they wanted to be shaved and nail care is done when they get a shower. If a resident refuses a shave or nail care, they check the "No" box but do not indicate it was refused.2. A record review for Resident 7 was completed on 8/23/2023 at 11:53 A.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following a cerebral infarction affecting the left non dominant side, bipolar disorder, dementia with agitation, and paranoid personality disorder. An Admission Minimum Date Set (MDS) assessment, dated 7/30/2023, indicated that he was extensive assist of one for personal hygiene		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **DNS/Designee will audit 5 residents weekly X12 weeks, then 3 residents weekly X12 weeks, then 1 resident weekly X12 weeks to ensure residents are shaven and have clean fingernails. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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
	and total dependent for bathing. During an interview and observation, on 8/20/2023 at 6:35 P.M., Resident 7 was unshaved, facial hair with growth above the lip, sideburns and chin and he indicated he gets showers on Monday and Friday and does not want the facial hair. No one has offered to assist with shaving. During an observation on 8/21/2023 at 10:22 A.M., Resident 7 was not shaved. He indicated it was his shower day and hoped they shaved him. During an observation on 8/22/2023 at 9:38 A.M., resident was unshaved. During an observation on 8/23/2023 at 8:12 A.M., resident was unshaved. During an observation on 8/25/2023 at 12:25 P.M., resident was unshaved. During an observation, on 8/28/2023 at 9:16 A.M., resident was unshaved and indicted that he would like help with shaving. A shower sheet, dated 7/27/2023, the section for shampoo, nails and shave were not checked off as completed. A shower sheet, dated 8/3/2023, the section for nails and shave were not checked off as completed. A shower sheet, dated 8/10/2023, the section for nails and shaving - no was checked off. A shower sheet, dated 8/14/2023, the section for shave - no was checked off.			

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	08/28/2023

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 8/24/2023 at 9:12 A.M., CNA 3 indicated when she gave a shower, she gathers the supplies together then assists with washing of the hair and body, then dries and applies lotion. The nurse does a skin check then assists with dressing and transfers to chair or bed. During an interview, on 8/24/2023 at 11:52 A.M., CNA 1 indicated when she gives a shower, she gathers supplies together and depending how much the resident can do for themselves she has them participate. She starts with washing of the hair, a shave if needed, then assists them with washing the body. If they are independent, she gives them privacy, if assist is required, she stays with them. During an interview, on 8/24/2023 at 2:59 P.M., CNA 2 indicated when she gives a shower, she gets supplies together, provides privacy and checks the temperature of the water. She washes the resident's hair, checks for facial hair, cuts fingernails, reports any skin concern to the nurse, then dresses them. During an interview, on 8/24/2023 at 3:03 P.M., CNA 4 indicated when he gave a shower, he checked the water temperature first then provided privacy. He assists with shampooing hair, if facial hair is present shave, trim nails, wash the body and apply lotion. He reports any skin findings to the nurse. A Care Plan, dated 7/24/2023, indicated "[Resident name] needs assistance with activities of daily living dementia, hemiplegia affecting the left side. [Resident name] will have care needs met daily with assistance of staff." On 8/28/2023 at 1:28 P.M., the Regional Nurse			

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	08/28/2023

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
	Consultant, provided a policy titled, "Activities of Daily Living", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care....3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." 3.1-38(3)(D)(E)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, interview, and record review the facility failed to arrange an ophthalmology follow up appointment for 1 of 1 resident reviewed for vision and hearing. (Resident 11) Finding includes: A record review for Resident 11 was completed on 8/22/2023 at 3:22 P.M. Diagnoses included, but were not limited to: type 2 diabetes, moderate	F 0685	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Ophthalmology **consult referral sent to Michiana Eye Center for Resident #11 by Medical Records.** **2 How other residents**	09/30/2023

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	08/28/2023

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
	protein-calorie malnutrition, acquired total absence of pancreas, and chronic pain syndrome. During an interview on 8/20/2023 at 4:37 P.M., Resident 11 was concerned with going blind in his left eye. He was seen by the facility eye doctor and he was told of a cataract in his left eye that needed to be removed. A Quarterly Minimum Data Set (MDS) assessment, dated 11/3/2022, indicated he had impaired vision. A Progress Note, dated 10/31/2022, from the [name of provider] indicated that the patient wanted to proceed with surgery. Cataract surgery was recommended, ophthalmology consult with follow up in 4-5 months. A Progress Note, dated 4/19/2023, from the [name of provider] indicated the patient wanted to proceed with surgery. Cataract surgery was recommended and ophthalmology consult for left eye. During an interview, on 8/25/2023 at 10:10 A.M., the Director of Nursing indicated that the appointment was not made last year for the ophthalmology referral and should have been. On 8/25/2023 at 1:52 P.M., the Regional Nurse Consultant provided a policy titled, "Vision and Hearing Services", and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility to ensure that residents are provided with vision and hearing services as needed. All residents requiring vision and hearing services outside the facility will be assisted with the necessary arrangements as indicated...."		**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 have ophthalmology consults have the potential to be affected byt he alleged deficient practice. A review of all residents seen by in house eye doctor forms reviewed by DNS/Designee for the last 30 days for any referrals or consults that need to be scheduled. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **Social Services educated by Nurse Consultant on 9-28-23 to ensure all eye doctor forms given to nursing staff to ensure consults are completed.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **DNS/Designee will audit all in house eye doctor forms at each visit for 6 months to ensure any consults or referrals are scheduled. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until**	

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	08/28/2023

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
	3.1-39(a)(1)		**such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to ensure a resident with significant weight loss received fortified pudding as ordered for 1 out of 4 reviewed for nutrition. (Resident 13) Finding includes: The record review for Resident 13 was completed on 8/23/2023 at 10:00 A.M. Diagnoses included, but not limited to: anorexia, dementia without	F 0692	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **Resident #13 was given fortified pudding on 8-25-23 by the Dietary Manager. The facility is unable to correct the alleged deficient practice for 8-24 and 8-28-23. On 8-31-23**	09/30/2023

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	08/28/2023

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
	behavioral disturbances and chronic kidney disease stage 2. A Quarterly Minimum Data Set (MDS) assessment, dated 6/27/2023, indicated a weight loss. A Nutrition/Dietary Note, dated 7/13/2023, indicated Resident 13 triggered at 180 days significant weight loss of 11 pounds which is 9.8 % on 7/3/2023. Weight taken on 7/11 indicated an additional 9 pound weight loss in one week. Changed appetite stimulant the previous week. The current diet was continued, ice cream was discontinued at lunch and dinner and fortified pudding for lunch and dinner were started. A Physician Order, dated 4/7/2023, indicated "Regular diet Dys Adv texture, Regular (None/Thin) consistency, fortified pudding with lunch and dinner." A Care Plan, revised on 7/27/2023, indicated "... [Resident name] has potential for nutritional risk related to hx of weight loss, dx CKD, MDO, HTN,Mech soft diet r/t dentures, at times refuses to wear. BMI within healthy range. At times refuses supplements. Potential for unavoidable wt variance/compromised skin integrity r/t decline in health status. Fortified food to aid in wt stabilization. Intervention: Provide and serve supplements as ordered...." During an observation, on 8/24/2023 at 12:19 P.M., Resident 13 she was served lasagna, salad, garlic toast, fruit cocktail and milk for lunch. During an observation, on 8/25/2023 at 12:33 P.M., Resident 13 received ground beef, macaroni and cheese, green beans and cake for dessert. Her		**resident was assessed by Licensed Nurse with no negative outcomes noted from the deficient practice.** **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 are to receive fortified pudding have the potential to be affected by the alleged deficient practice. A review of all residents who are ordered to receive fortified pudding completed to ensure they received fortified pudding as ordered by Dietary Manager on 9-29-23. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff educated on ensuring they are following orders and placing fortified pudding on each tray as ordered by Dietary Manager on 9-29-23. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED/Designee will audit 5 meal trays weekly X12 weeks, then 3	

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	08/28/2023

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
	diet slip indicated she was to get fortified food for lunch and dinner, the fortified pudding parfait-1/2 cup was crossed out on the tray ticket. During an interview, on 8/25/2023 at 12:39 P.M., the Dietary Manager indicated that they served fortified potatoes for lunch today and that was the only fortified food that was served. During an observation, on 8/28/2023 at 12:23 P.M., Resident 13 was served ground meat, sweet potatoes, spinach, pineapple tidbits and milk. During an interview, on 8/25/2023 at 12:25 P.M., CNA 8 indicated that they do not put the fortified pudding on the tray the kitchen does. She was unaware of why it was not on the tray. During an interview, on 8/25/2023 at 12:30 P.M., the Dietary Manager indicated that they served fortified mashed potatoes and chocolate pudding, and Resident 13 was served the pudding . Friday, they did not have any fortified pudding so those who received fortified food received mashed potatoes. During an observation, on 8/25/2023 at 12:42 P.M., the Dietary Manager was going down the hall with a white cup and indicated she had Resident 13's fortified pudding. On 8/24/2023 at 2:35 P.M., an Executive Director provided a policy titled, "Nutritional and Dietary Supplements," undated, and indicated the policy was the one currently used by the facility. The Policy indicated "...2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs...."		meal trays weekly X12 weeks, then 1 tray weekly X12 weeks to ensure fortified pudding is on the tray as ordered. **Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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
	3.1-46(a) (1)(2)			
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 observation, record review and interview, the facility failed to ensure oxygen and respiratory equipment use was ordered and care planned for 2 of 28 residents reviewed for respiratory needs. (Resident 28 and 41) Findings include: The clinical record for Resident 28 was reviewed on 8/23/2023 at 2:21 P.M. Resident 28 was admitted to the facility on 3/9/2023 with diagnoses included, but not limited to: s/p cerebral vascular disease, hypertensive heart disease, atherosclerotic heart disease, type 2 diabetes mellitus, osteoarthritis left knee and hip, chronic gout, hyperlipidemia, dysphagia following cerebral vascular accident and sleep disorder. The most recent Minimum Data Set (MDS) assessment for Resident 28, completed on 8/8/2023 indicated the resident was moderately cognitively impaired,, had not exhibited any behaviors, and required extensive staff assistance of one staff for bed mobility, wheelchair locomotion, dressing and personal hygiene and	F 0695	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #28 assessed for need of oxygen and orders and care planned as necessary. Resident #28 was assessed on 8-29-23 with no negative outcomes. CPAP orders entered for Resident #41, and CPAP machine set up as ordered. Resident #41 assessed on 9-4-23 with no negative findings noted. **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 CPAP's and oxygen have the potential to be affected by the alleged deficient	09/30/2023

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	08/28/2023

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
	required the staff assistance of two staff for transfers and was totally dependent of one staff for bathing needs. The resident was not assessed to utilize supplementary oxygen. Review of the current care plans for Resident 28 indicated there was no plan to address the resident's use of continuous oxygen therapy. Resident 28 was observed on 8/21/23 at 3:20 P.M., lying in bed with oxygen at 2 liters per nasal cannula. The resident was noted to have a loose cough . The resident indicated he had the cough for awhile, the oxygen use was newer and sometimes they gave him lozenges for his cough. The resident was noted to exacerbate his coughing when he attempted to talk. Resident 28 was observed, on 8/23/23 at 2:42 P.M., lying in his bed with oxygen at 2 liters per nasal cannula. The resident was noted to be coughing. Resident 28 was observed on 8/28/23 at 9:55 A.M., lying gin his bed with oxygen at 2 liters per nasal cannula. The Physician's orders for Resident 28 did not include any orders related to supplementary, continuous oxygen use. The Medication Administration Record and the Treatment Administration Record for August 2023 did not contain any place to document the oxygen use for Resident 28. The Nursing Progress Note, indicated on 8/10/2023 the nurse practioner noted the resident coughing and wheezing and ordered a chest x-ray and rapid COVID test. The documentation indicated the COVID rapid test was negative.		practices. Review of all residents to determine if oxygen needed or not completed by DNS/Designee by 9-29-23 and updated as needed. A review of all admission completed by the DNS/Designee by 9-29-23 completed to ensure any CPAP orders are entered into PCC. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff educated to obtain orders from Md/NP and place in pCC if oxygen is applied by DNS/Designee by 9-29-23. Nursing staff educated to ensure admission orders are double checked and entered in PCC by DNS/Designee by 9-29-23.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit of 5 residents weekly X12 weeks, then 3 residents weekly X12 weeks then 1 resident weekly X12 weeks will be completed to ensure there are orders in PCC if they have oxygen on. All admissions will be audited daily X12 weeks, then 3 times weekly X12 weeks then	

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	08/28/2023

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 Progress Note, dated 8/14/2023 indicated the resident's chest x-ray was positive for an infiltrate (pneumonia) and an antibiotic was ordered for the resident. There was no documentation the resident required or was utilizing oxygen per nasal cannula. During an interview with RN 10, on 8/28/23 at 9:53 A.M., regarding Resident 28's oxygen use, she indicated there was no active order for oxygen for Resident 28. She indicated the resident had not needed any oxygen for her lately so she had not "set" it up for him. RN 10 seemed unaware the resident had been observed with continuous oxygen therapy use during the survey. Review of the most recent vital signs oxygen saturation documentation, only 2 of the most recent 28 assessments, from the dates of 8/18/2023 to 8/27/2023 acknowledged the use of the oxygen. Review of the facility policy and procedure, titled, "Oxygen Administration" provided by the Regional nurse consultant on 8/28/2023 included the following: "...Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration...Assessment Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis 2. Signs or symptoms of hypoxia 3. Signs or symptoms of oxygen toxicity...5. Lung sounds;...."2. During an observation and interview, on 8/21/2023 at 2:00 P.M., a CPAP (continuous positive airway pressure) machine was observed on a table in Resident 41's room. The resident indicated that it was his and he had not used it since his admission to the facility		weekly **X12 weeks to ensure all admission orders are entered correctly. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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
	because the power cord was missing and thought it might be in a bag in his closet. He couldn't get anyone to look in the bag. He indicated he used it for 2 years at the previous facility and for about 4 years at home before that. He further indicated he would frequently wake up at night because he cannot breathe properly. During a record review, conducted on 8/23/2023 at 11:31 A.M., Resident 41's diagnoses included, but were not limited to: Parkinson's disease, COPD (chronic obstructive pulmonary disease), and obstructive sleep apnea. The Quarterly MDS (Minimum Data Set) assessment, dated 7/28/2023, included, but was not limited to: resident had intact cognition. He had shortness of breath when lying flat. He was not using oxygen or other respiratory treatments. A Care Plan problem, dated 11/21/2022, included, but was not limited to: resident is at risk for respiratory distress related to COPD, sleep apnea, and unable to lie flat due to causes shortness of breath. The goal indicated that the resident would be free from symptoms of respiratory distress. Interventions included, but were not limited to: administer medications as ordered, elevate head of bed to alleviate shortness of breath caused by lying flat, notify physician of changes in respiratory pattern, and notify physician of new or worsening signs of respiratory infections. Documents from (a facility the resident has resided at previously) sent with resident at admission, on 11/18/2022, indicated a physician order, dated 5/11/2022, for CPAP at bedtime. On 2/28/2023 resident had an appointment with [name of physician], a cardiologist, for episodes of			

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	08/28/2023

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
	bradycardia, low heart rate. The Physician recommended an echocardiogram but would not do a holter monitor until resident was on CPAP, as his heart rate would decrease at night due to his obstructive sleep apnea. During an interview, on 8/28/2023 at 2:03 P.M., the Regional Nurse indicated the CPAP should have been followed up on when Resident 41 was admitted to the facility on 11/18/2022 and was not. A current policy titled, "Admission Orders" was undated, and provided, on 8/28/2023 at 2:38 P.M., by the Regional Nurse, included, but was not limited to: " ...The written and/or verbal orders should include at a minimum: a. Dietary b. Medication orders if indicated c. Routine care orders ...." 3.1-47(a)(6)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, record review and interview, the facility failed to ensure a plan was in place to provide trauma-informed care for 1 of 1 residents reviewed for Post Traumatic Stress Disorder. (Resident 44) Finding includes:	F 0699	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #44's care plan updated to reflect PTSD and any triggers identified by Social Services	09/30/2023

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	08/28/2023

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. The record for Resident 44 was reviewed on 8/22/2023 at 2:44 P.M. Resident 44 was admitted to the facility with diagnosis, including but not limited to: type 1 diabetes mellitus, proliferate diabetic retinopathy without macular edema, legal blindness, post traumatic stress disorder (PTSD)\, bipolar disorder and schizoaffective disorder, bipolar type. The following diagnosis were added on 7/7/2023: intermittent explosive disorder and mild cognitive impairment of uncertain or unknown etiology, other problems elated to housing an economic circumstances and problems related to other legal circumstances. The resident was sent for an in patient psychiatric stay on 7/3/2023 and was readmitted to the facility on 7/8/2023. The initial MDS assessment, completed for the Admission assessment, on 6/16/2023 indicated the resident was alert and oriented, felt down, depressed and bad about themselves most days, had not exhibited any behaviors, required limited assistance for personal hygiene, toileting, eating and dressing. The care plans for Resident 44 included a plan to address the resident's history of smoking and current use of Vapes, a plan to address the resident's mild cognitive impairment, a plan to address the resident psychotropic medication use, a plan to address the resident's mood issues. An Acute Psychiatric Hospital Note, from 7/8/2023, indicated the resident was transferred to the hospital due to becoming verbally and physically abusive to other residents and a plan to address the resident's agitation, depression and anxiety. There was no plan to address the resident PTSD and no triggers and resident centered interventions to address the PTSD		Consultant on 9-28-23. Resident assessed on 9-9-23 by Licensed Nurse with no negative outcomes. **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 PTSD have the potential to be affected by the alleged deficient practice. Social Services Consultant reviewed all residents with PTSD diagnosis and ensured PTSD is care planned and triggers identified on 9-28-23. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **4 Social Services and nursing educated by DNS on 9-28-23 to ensure all residents with PTSD have a care plan and triggers identified.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **DNS/Designee will audit 5 residents weekly X12 weeks then 3 residents weekly X12 weeks then 1 resident weekly**	

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	08/28/2023

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
	diagnosis. A Behavior Health Note, dated 7/14/2023 indicated staff were to continue to document any new and/or worsening behavior but there was no information or insight regarding the resident's PTSD triggers. During an interview, on 8/28/2023 at 9:37 A.M., with CNA 9 she indicated she knew the resident sometimes threw things but she did not know what his "triggers" were regarding his behaviors. She indicated if he was having a behavior, she would just wait and watch from a distance until he calmed down. She indicated she thought his trigger was "if he doesn't get what he wants." She reviewed the care plans on the computer screen but indicated she did not find a "trigger" defined but did indicate she was to monitor the resident for the behaviors of yelling, screaming and throwing things. During an interview, on 8/28/2023 at 10:12 A.M., with the SSD (Social Service Director) she indicated she was new to the facility and did not see a care plan or documentation related to Resident 44's PTSD diagnosis and/or triggers. She indicated she did not yet know the triggers for Resident 44's PTSD diagnosis. Review of the facility policy and procedure, titled "Trauma Informed Care" provided by the Regional Nurse Consultant on 8/28/2023 at 11:46 A.M., included the following: "...2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of previous traumatic event, as well as screen and assessment tools such as the		**X12 weeks to ensure PTSD diagnosis is care planned and triggers identified. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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 Assessment Instrument (RAI), Admission Assessment,,, the history and physical, the social history assessment, and others...4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professional) to develop and implement individualized care plan interventions...6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific intervention will identify ways to decrease the resident's exposure to triggers which will re-traumatize the residents, as well as identify ways to mitigate or decrease the effect of the trigger on he resident, and will be added to the residents care plan. While most triggers are highly individualized, some common triggers may include but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. b. exposure to loud noises, or bight/flashing lights. c. Certain sighs, such as objects that are associated with there abuser. d. Sounds, smells and physical tough...." 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including			
F 0755 SS=D Bldg. 00				

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	08/28/2023

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
	procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure medication was available for administration in 2 of 3 residents reviewed who received anxiolytic (anti-anxiety) medication. (Resident C and G) Finding includes: During an interview, on 8/21/23 at 1:45 P.M., Resident C indicated he was supposed to take 3 medications in a certain time frame, like Valium but with a different name, to keep his leg from spasming. He doesn't believe there is a back up pharmacy and the back up medications in the facility isn't kept full and runs out often. On 8/26/23 at 10:12 A.M., a review of the clinical record for Resident C was conducted. The	F 0755	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **The facility is unable to correct the alleged deficient practice for Resident C and G. Both residents assessed by DNS with no negative outcomes.** **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 receive**	09/30/2023

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	08/28/2023

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's diagnoses included, but was not limited to: nontraumatic compartment syndrome of left lower extremity, epilepsy, schizoaffective disorder-bipolar, cognitive communication deficit, anxiety and muscle weakness/spasms. A copy of the hand written prescription, dated 5/2/23, indicated "...Diazepam 2.5 mg [milligrams] PO [by mouth] in the afternoon...." A copy of the handwritten prescription, dated 5/2/23, indicated "...Diazepam 5 mg [milligrams] PO [by mouth] BID [twice a day]...." A Physician order was received 6/8/23 to change the afternoon dose of Diazepam to 5 mg. The order was for Diazepam 5mg three times a day (TID) Narcotic Count form indicated, on 5/3/23 at 4:00 A.M., thirty tablets of diazepam 5mg were received. Narcotic Count form indicated three 5 mg tablets were administered to the resident, for the prescribed times 8:00 A.M. 12:00 P.M. and 9:00 P.M., on 5/3, 5/4, 5/5,5/6,5/7,5/8,5/9,5/10,(5/10-note stated "removed 5 tabs for resident" to take LOA (leave of abscence), 5/12, 5/16, 5/17, 5/18, 5/19,5/20, 5/21, 5/22, 5/23, and 5/24/23. There was no narcotic count form received after 5/25/23. The afternoon dose, on each date listed, did not indicate the destruction of half the 5 mg tablet. The Medication Administration Record (MAR) indicated the resident had not been administered the Diazepam on 5/14, 5/15, 5/25 and 5/26. It was documented "...Other/see Progress Notes...." There were no progress notes to explain why the resident had not been administered his Diazepam as ordered.		**Diazepam and Ativan have the potential to be affected by the alleged deficient practice. DNS/Designee audited all residents with orders for Diazepam and Ativan to ensure medication was available on 9-29-23.** **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff educated by DNS to ensure medications are ordered timely and if not available to call pharmacy and have medications sent by 9-29-23.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS/Designee will audit 10 residents weekly X12 weeks then 5 residents weekly X12 weeks then 3 residents weekly X12 weeks to ensure medications are available. **Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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 Narcotic Count form indicated, on 5/3/23 at 4:00 A.M., thirty tablets of diazepam 5 mg. were received and last dose was documented, as removed for administration, on dated 5/12/23 at 8:00 P.M. The Narcotic Count form indicated on 5/16/23 at 4:00 A.M., the facility received thirty more diazepam 5 mg tablets, with the last dose was documented, as removed for administered, on 5/25/23 at noon. During an interview, on 8/28/23 at 4:40 P.M., the Director of Nursing (DON) indicated the normal procedure to prevent the resident from running out of a medication was to order more, from the pharmacy, at least a few days ahead. She indicated the EDK (Emergency Drug Kit) did not contain diazepam so the nurses could not pull one when they ran out. She indicated the resident should not of went without his diazepam. On 8/23/23 at 11:46 A.M., the Regional Nurse Consultant provided a policy titled, "Emergency Drug Kit Standards", dated 2/1/18, and indicated the policy was the one currently used by the facility. The policy indicated "...1) The pharmacy in collaboration with the facility Medical Director, Director of Nursing (DON), and Administrator (or Corporate Designee(s) will determine what medications will be supplied in the Emergency Drug Kit(s) (EDKs)...2) The contents/medications and quantities will be reviewed periodically or as requested, but no less than quarterly...." On 8/23/23 at 4:02 P.M., the Regional Nurse Consultant provided a policy titled, "Medication Orders", dated 2/1/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Refills should be requested by the licensed nursing staff/authorized personnel two (2) to four (4) days prior to the resident's			

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	08/28/2023

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
	current supply being exhausted...." 2. An self-reported incident #320, dated 7/27/23 at 12:01 P.M., indicated "...10 ml [milliliter] of Ativan not found in fridge. Family and MD [Medical Doctor] were notified of the incident...." The investigation of the incident had all staff involved suspended, police were notified and the missing medication was replaced by the facility. The staff involved were RN 2, LPN 3 and LPN 4. The police report number was 20230003109 and was filed, on 7/28/23, for Resident G, indicating the resident had medication Ativan "stolen". A statement by LPN 4, undated, indicated she had worked, on 7/26/23, on the day shift (6:00 A.M. to 6:00 P.M.) and she had administered 0.5 ml of Ativan to the resident, as ordered. A statement by LPN 3, dated 7/27/23, indicated LPN 3 was the oncoming nurse and all counts of medications were correct when she left the facility. A statement by RN 2, dated 7/27/23, indicated she had noticed a liquid Ativan was missing after she began her shift. All three nurses above tested negative for control substances. On 8/28/23 at 2:10 P.M., a review of the clinical record for Resident G was conducted. The resident's diagnoses included, but was not limited to: renal disease with dependence on renal dialysis and generalized anxiety disorder. An Order Summary Report indicated "...Lorazepam [Ativan] Oral Concentrate 2 mg/ml [milligrams per milliliter]. Give 0.5 ml by mouth one time a day every Mon. Tues, Wed, Thu, Fri for anxiety Give			

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	08/28/2023

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
	prior to dialysis...." The start date for administration was 5/3/23 The Medication Administration Record (MAR) indicated the resident had been administered the Ativan, as prescribed, until 5/27/23. On 5/27/23 there were no initials indicating the nurse had administered the Ativan, as ordered. During an interview, on 8/28/23 at 4:40 P.M., the Director of Nursing (DON) indicated the vial of Ativan was never found. On 8/23/23 at 10:25 A.M., the Regional Nurse Consultant provided a policy titled, "Abuse Prevention Program", dated 2/2018 and revised on 3/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent...." This Federal tag relates to Complaint IN00409479. 3.1-25(a) 3.1-25(g)(2) 3.1-25(g)(3)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.			

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	08/28/2023

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
	§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, record review, and interview, the facility failed to ensure a pharmacy recommendation for a PRN medication was re-evaluated and signed by a physician for 1 out of 5 residents reviewed for unnecessary	F 0756	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**	09/30/2023

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	08/28/2023

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
	medication. (Resident 11) Finding includes: A record review for Resident 11 was completed on 8/22/2023 at 3:22 P.M. Diagnoses included, but were not limited to: type 2 diabetes, moderate protein-calorie malnutrition, acquired total absence of pancreas, and chronic pain syndrome. A Pharmacy Recommendation, created between 4/1/2023 and 4/5/2023, for Resident 11, indicated "...This resident has a PRN order for Compazine. Compazine or prochlorperazine is considered an anti-psychotic though it can be used to treat nausea and vomiting. Therefore, according to federal requirement, a PRN order for Compazine is limited to 14 days. A new PRN order cannot be renewed unless the attending physician or prescribing practitioner first evaluates the resident to determine if entering a new order for the PRN medication is appropriate. If Compazine is being used to treat nausea and vomiting, please consider an alternative antiemetic agent if clinically appropriate...." The Pharmacy Recommendation, response was marked agree for 14 days, signed by the Director of Nursing, dated 3/31/2023. During an interview, on 8/25/2023 at 11:29 A.M., the Director of Nursing indicated she is not authorized to sign pharmacy consults. When she receives the consult, she prints them out and she goes thru them with the doctor, follows up on the orders then files them away. A Physician Order, with a start date of 3/4/2023, indicated Prochlorperazine tablet 10 milligrams by mouth every 8 hours as needed for nausea and		**Compazine was discontinued per pharmacy recommendations and NP approval for Resident 11 on 9-29-23. Resident #11 was assessed by Licensed Nurse on 9-5-23 with no negative effects noted.** **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 have pharmacy recommendations have the potential to be affected by the alleged deficient practice. A review of the last 30 days of pharmacy recommendations completed by DNS by 9-30-23 to ensure pharmacy recommendations are completed and signed by MD/NP.** **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 in-serviced by Nurse Consultant to ensure MD/NP signs pharmacy recommendations timely and that orders are entered into PCC.** **4 How the corrective**	

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	08/28/2023

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
	vomiting without a stop date. A Medication Administration Record, dated May 2023, indicated that Prochlorperazine was administered on 5/15/2023. A Medication Administration Record, dated June 2023, indicated that Prochlorperazine was administered on 6/16/2023, 6/20/2023 and 6/29/2023. During an interview, on 8/25/2023 at 11:30 A.M., the Director of Nursing indicated that the order should have been discontinued and not given in May and June of 2023. On 8/25/2023 at 1:52 P.M., the Regional Nurse Consultant provided a policy titled, "Medication Regimen Reviews," dated May 2019, and indicated the policy was the one currently used by the facility. The policy indicated "...12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it...." On 8/25/2023 at 1:52 P.M., the Regional Nurse Consultant provided a policy titled, :Medication Orders," undated, and indicated the policy was the one currently used by the facility. The policy indicated,"...1. Medications should be administered only upon the signed order of a person lawfully authorized to prescribe...." 3.1-25(i)		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **DNS/Designee will review 15 pharmacy recommendations each month X6 months to ensure they are signed by MD/NP and entered into PCC. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free			

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	08/28/2023

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
	from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, record review and interviews, the facility failed to ensure insulin was administered at the correct time for 1 of 2 residents reviewed for insulin administration. (Resident 2) Finding includes: On 8/23/2023 at 10:15 A.M., LPN 5 was notified of the need to observe blood glucose assessments and insulin administration prior to the noon meal. LPN 5 indicated she had three residents on her cart for whom she checked blood sugar levels and administered insulin. LPN indicated she usually completed the assessment between 11:00 - 11: 30 A.M. On 8/23/2023 at 11:15 A.M., LPN 5 was not observed on her nursing unit. She returned to the nursing unit at 11:40 A.M. and indicated she had already assessed blood sugar levels and administered her insulin for the noon meal.	F 0757	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility is unable to correct the alleged deficient practice for Resident #2. Resident 2 assessed by Licensed Nurse on 9-1-23 with no negative findings noted. **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 receive insulin	09/30/2023

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	08/28/2023

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
	Review of the medication administration record for Resident 2, on 8/23/2023 at 3:00 P.M., indicated LPN 5 had administered 3 units of Humalog insulin at 10:45 A.M. Resident 2 was observed lying in his bed awake on 8/23/2023 at 11:30 A.M. He did not have any food and/or drinks other than water on his overbed tray. Resident 2 was not served his lunch meal tray until 12:23 P.M., one hour and 22 minutes after receiving his insulin. Review of the facility policy and procedure, titled, "Timely Administration of Insulin" provided by the Regional Nurse Consultant on 8/25/2023 at 10:30 A.M. included the following: "...4. Insulin administration will be coordinated with meal times and bedtime snacks unless otherwise specified in the physician order... Review of the manufacturer's instructions for Humalog insulin included the following: "...you should take Humalog or Humalog Mix up to 15 minutes before you eat a meal. But you can also take your dose right after finishing a meal. " The instructions also indicated the insulin was a fast acting medication that started working in 15 minutes. 3.1-48(a)(1)		have the potential to be affected by the alleged deficient practice. DNS/Designee observed insulin administration of 10 residents on 9-7, 9-12, 9-19 and 9-27 with no deficient practice noted. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff educated by DNS/Designee by 9-29-23 of appropriate times to administer insulin before mealtimes.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS/Designee will audit 10 insulin dependent residents weekly X12 weeks then 5 residents weekly X12 weeks then 3 residents weekly X12 weeks to ensure insulin is administered at the appropriate time. **Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0759 SS=D	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More			

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	08/28/2023

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
Bldg. 00	§483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of greater than 5% for 3 of 9 residents observed during medication pass. Five medication errors were observed during 39 opportunities. This resulted in a medication error rate of 12.82 percent. (Resident 141, 140, and 83) Finding includes: 1. During an observation of a medication administration pass, conducted on 8/22/2023 at 11:01 A.M., QMA 13 removed two Lidocaine 4% patches from a box, dated and signed the patches and administered the patches to the right thigh and right buttocks of Resident 141. Review of the Physician's order for the Resident 141's Lidocaine 4% patches, indicated they were to be applied to the resident's right shoulder and right thigh. 2. During an observation of a medication administration pass, conducted on 8/23/23 at 9:25 A.M., QMA 14 prepared and administered the following medications to Resident 140: Aspirin 81 mg (milligram) one tablet. Daily vitamin, one tablet. Vitamin b1 100 mg. One tablet, Eliquis 5 mg tablet. Folic Acid 1 mg one tablet. Review of the Physician's orders for Resident 140 indicated the resident was scheduled to receive	F 0759	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **The facility is unable to correct the alleged deficient practice for Resident 141, 140 and 83 due to those identifying numbers are not listed on the sample list provided to 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 have the potential to be affected by the alleged deficient practice. Ten random nurses audited on medication administration by DNS on 9-29-23 with no negative findings. **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 in-serviced QMA's and Nurses on safe medication administration by 9-29-23.**	09/30/2023

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	08/28/2023

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
	the administered medications and the following medications: Vitamin D 1000 mg one tablet upon rising. Ferrous Sulfate 325 mg one tablet upon rising. Calcium Carbonate 1250 mg twice a day. Review of the Medication Administration Record for Resident 140 for 8/23/2023 indicated QMA 14 signed at the same time,, she had given all 8 of the ordered medications but she was only observed to have administered 5 of the scheduled 8 medications. 3. During an observation of a medication administration pass, conducted on 8/23/23 at 9:45 A.M., RN 15 was observed preparing medications for Resident 83. One of the medications was an Incruse Elipta inhaler. The resident was to receive one puff once a day. RN 15 noticed the inhaler was empty prior to entering Resident 83's room. RN 15 went to the medication room and checked in the Emergency drug machine, but the machine did not have the correct inhaler available. RN 15 indicated she would have to try to order a new inhaler later for Resident 83. 3.1-48(c)(1)		**4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **DNS/Designee will conduct random medication administration audits for 5 nurses weekly X12 weeks then 3 nurses weekly X12 weeks then 1 nurse weekly X12 weeks to ensure compliance with medication administration. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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	08/28/2023

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
	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were labeled and dated in 1 of 2 medication storage rooms and 1 of 2 medications carts. Findings include: 1. During an observation of the South Medication Room, on 8/23/2023 at 3:08 P.M., with the North Unit Manager, an opened bottle of Konvomep insulin for Resident 137 was located in the refrigerator. The North Unit Manager confirmed there was no open date and indicated there should have been. 2. During an observation of the North Medication Cart, on 8/24/2023 at 2:30 P.M., with QMA 11, the following medications were noted to be labeled and opened but had no date to indicate when they had been opened: A bottle of Lispro insulin for Resident 138.	F 0761	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **Medications for Residents 138, 46, 41, 12, 34, 23 and 26 reordered from pharmacy and dated when opened. All loose pills removed from medication cart. Identifiable residents assessed by Licensed Nurse with no negative effects noted.** **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 have the potential to be affected by the alleged deficient	09/30/2023

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	08/28/2023

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 tube of Mupiricon ointment for Resident 46. A Trilegy inhaler for Resident 46. A Flutiicasaline aerosol vial for Resident 46. An albuterol inhaler for Resident 41. A large container of Peg 3350 powder for Resident 12. A large container of Peg 3350 powder for Resident 34. A large bottle of Milk of Magnesia for Resident 12. A large bottle of Almacone double strength for Resident 23. A large bottle of Mylanta maximum strength for Resident 12. A large bottle of Almacone double strength for Resident 34. A Trilegy inhaler with [name of resident] written on the inhaler had no pharmacy label and no open date. QMA 11 indicated it belonged to Resident 26. 3. During an observation of the medication cart for the South unit, on 8/26/2023 at 11:25 A.M., with RN 12, there were 12 loose pills located underneath the medication punch carts in the cart. During an interview with RN 12, on 8/26/2023 at 11:26 A.M., she indicated there should not have been loose pills in the medication cart. A policy regarding dating and labeling of medications was requested on 8/28/2023 and not received prior to the survey exit.		practice. All medication carts audited to ensure all medications present, dated when opened and no loose pills noted. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff educated by DNS to ensure medications are dated when opened and no loose pills noted in the medication cart.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DNS/Designee will audit medication carts 3 times weekly X12 weeks then 2 times weekly X12 weeks then weekly X12 weeks to ensure medications are labelled with date open and no loose pills are noted. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services			

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	08/28/2023

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
	The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for			

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	08/28/2023

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
	reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents reviewed for dental services had a dental examination completed (Resident 28) and 2 of 3 residents reviewed for dental needs had dental recommendations completed timely for outside referrals. (Resident 72 and 11) Findings include: 1. The clinical record for Resident 28 was reviewed on 8/23/2023 at 2:21 P.M. Resident 28 was admitted to the facility on 3/9/2023 with diagnoses included, but not limited to: status post cerebral vascular disease, hypertensive heart disease, atherosclerotic heart disease, type 2 diabetes mellitus, osteoarthritis left knee and hip and age related debility. The most recent Minimum Data Set (MDS) assessment for Resident 28, completed on 8/8/2023 indicated the resident was moderately cognitively impaired,required extensive staff assistance of one staff for personal hygiene and required the staff assistance of two staff for transfers and was totally dependent of one staff for bathing needs. The Admission MDS assessment indicated the resident had his own teeth and did not have any dental issues. The current care plans for Resident 28 included a plan to address the resident's oral/dental health problems due to missing teeth, poor oral hygiene and teeth in poor condition. Interventions included arranging or providing for transportation	F 0791	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents **28 and 11 are to be seen by the facility in house dentist at next visit. Resident 72 had appointment scheduled on 9-21-23. Resident 11 had appointment on 9-29-23 for consultation of teeth extractions but tested positive for Covid so appt to be rescheduled when out of isolation.** **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 need to see the dentist have the potential to be affected by the alleged deficient practice. A review of all consents completed by Social Services on 9-29-23 and if requested to see the dentist then those residents added to the list for the next visit. A review by Social Services on 9-29-23 completed of the last 30 days of residents seen by the dentist to ensure any consults/referrals are scheduled. **3 What measures will be put**	09/30/2023

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	08/28/2023

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
	for dental services. A consent for dental services was signed by the resident on 3/10/2023. During an interview with Resident 28, on 8/21/23 at 3:17 P.M., he indicated he had not seen a dentist since his admission. During an interview with the Regional Nurse Consultant, on 8/28/2023 at 3:30 P.M., she indicated the resident had been "missed" when setting up dental examinations by the facility's dental provider but would be put on the "list" for the next visit. 2. The record for Resident 72 was reviewed on 8/25/2023 at 2:11 P.M. Resident 72 was admitted to the facility with diagnoses, included but not limited to: chronic obstructive pulmonary disease, systolic congestive heart failure, diabetes type 2 and history of nicotine dependence and alcohol dependence. The most recent Quarterly MDS assessment, completed on 7/23/2023, indicated the resident was alert and oriented and required limited assistance of one staff for personal hygiene needs.There were no dental issues identified on the assessment. The current care plans for Resident 72 included a plan to address the resident's missing and broken teeth. The goal was for the resident to be free from infection, pain or bleeding in the oral cavity. Interventions included coordinating and arranging for dental care and transportation as needed and/or as ordered During an interview with Resident 72, on 8/21/23		**into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DNS and Social Services educated by Nurse Consultant to ensure all residents are see by the dentist as needed on 9-28-23. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **DNS/Designee will audit 5 residents weekly X12 weeks, then 3 residents weekly X12 weeks then 1 resident weekly X12 weeks to ensure they do not need dental services. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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
	at 3:42 P.M., he exposed his upper gum line and teeth. The resident's front four teeth on the upper gum line were either missing, broken or had roots exposed. The resident indicated he had not seen a dentist but needed to see a dentist. A dental examination, dated 2/25/2023 for Resident 72 recommended the resident be referred to an outside provider for extraction of his remaining upper teeth and specific lower teeth so a full upper denture and partial lower denture could be made after the gums were healed. A dental exam on 5/29/2023, for Resident 72, recommended for the resident to be referred to an outside provider for tooth extractions and an oral cyst extraction so a full upper and partial lower denture could be made for the resident. During an interview on 8/28/2023 at 10:21 A.M., with the SSD (Social Service Director), she indicated she was new and did not see any information regarding the referral for Resident 72's dental needs. However, after checking with the Medical Records staff person, the SSD indicated on 5/30/2023 an approval from the facility's dental provider was documented for Resident 72 to see an outside dental office for recommended services. She indicated on 6/5/2023 the Medical Records staff member had contact a local dental provider and had scheduled Resident 72's teeth extraction for 9/21/2023. Review of the facility current policy and procedure, titled "Dental Services and Missing Dentures, provided by the Regional nurse consultant on 8/28/2023 at 11:46 A.M., included the following: "...The facility will obtain contracted outside dental services to meet the routine an emergency dental needs of each			

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	08/28/2023

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...The facility will assist in scheduling and transporting resident to dental appointments as needed. Efforts will be made to minimize out of pocket costs to the resident or representative as applicable by attempting to utilize low cost transportation, etc, the facility will make promptly, within three days, referrals to dental services...."3. A record review for Resident 11 was completed on 8/22/2023 at 3:22 P.M. Diagnoses included, but were not limited to: type 2 diabetes, moderate protein-calorie malnutrition, acquired total absence of pancreas, and chronic pain syndrome. He was admitted to the facility on 9/9/2022. During an observation and resident interview, on 8/20/2023 at 4:25 P.M., Resident 11 indicated that he needed new dentures because he had teeth that were broken on the top plate, and he had one tooth left on the bottom that hurt and he had not seen a dentist since he admitted to the facility. A Dental Consent for (dental provider name), dated 9/12/2022, was electronically signed by Resident 11. A Physician Order, dated 5/30/2023, indicated Resident 11 was started on Penicillin V 500 milligrams, four times a day for seven days for tooth pain. During an interview, on 8/28/2023 at 2:25 P.M., the Regional Nurse Consultant indicated that he had not been seen by the dental group and he should have been. 3.1-24			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	08/28/2023

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
	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure food items and drinks were covered when transporting 15 trays to residents who resided on the North hallway who received a meal tray on 8/21/23. Finding includes: During an interview, on 8/21/23 at 11:59 A.M., Resident C indicated he eats in his room, receives a tray of food and the only thing covered is the main dish. The rest of the meal had no lids, to cover the food. Resident indicated this morning his oatmeal had no cover on it and he won't eat anything that doesn't have a lid on it. He indicated he doesn't know if someone coughed over it or what.	F 0812	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **The facility is unable to correct the alleged deficient practice for Resident C and 140. The facility is unable to assess Resident C and 140 as their numbers/letters are not identified on the sample list provided to the facility.** **2 How other residents having the potential to be affected by the same deficient practice will be identified and**	09/30/2023

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	08/28/2023

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 8/21/23 at 12:14 P.M., the Resident C's meal tray arrived to the room and was observed to have no lid or covering over his coffee, water, fruit or vegetable. On 8/21/23 at 12:18 P.M., Resident 140's meal tray was observed being transported down the hallway to his room. The tray was observed to have coffee, fruit and water, uncovered, on the tray. The staff member carrying the tray down the hallway indicated she transports the meal trays from the service cart, located at the nurses station, to the residents room. On 8/21/23 at 12:20 P.M., the service cart was observed at the nurse's station with 8+ meals and none of the drink or food items were covered, only the main dish, which had a plate warmer and lid. During an interview, on 8/23/23 at 2:51 P.M., the Dietary Manager and the District Manager indicated their usual procedure was to cover all the drinks and other items, not inside the plate warmer. She had no idea why they were not covered on Monday during the lunch meal hall tray deliveries. On 8/23/23 at 3:11 P.M., the Dietary Manager indicated 15 residents received hall trays on the North unit on Monday 8/21/23. On 8/24/23 at 2:45 P.M., the Corporate from sister facility provided a policy titled, "Food Safety Requirements", dated February 2023 and indicated the policy was the one currently used by the facility. The policy indicated '...5. Foods and beverages shall be distributed and served to resident in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not		**what corrective action(s) will be taken:** **All residents have the potential to be affected by teh alleged deficient practice.** **ED/Designee observed 10 random dietary trays to ensure all items are covered on 9-13, 9-21 and 9-26.** **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff educated to ensure all meal items are covered by 9-29-23 by Dietary Manager. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED/Designee will audit 10 meal trays weekly X12 weeks then 5 meal trays weekly X12 weeks then 3 meal trays weekly X12 weeks at various times to ensure meal items are covered. **Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	

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	08/28/2023

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
	limited to: a. Covering all foods when traveling a distance)i.e., down a hallway, to a different unit or floor)...." On 8/24/23 at 2:48 P.M., the District Manager provided a policy titled, "Meal Distribution", dated 5/2014, revised on 9/2017 and indicated the policy was the one currently used by the facility. The policy indicated '...Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner... 3. All foods that are transported to dining areas that are not adjacent to the kitchen will be covered...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			

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	08/28/2023

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
	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	08/28/2023

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
	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to ensure 1 of 3 nursing staff passing medications followed manufacturer's recommendations for the cleaning of a glucometer. Finding includes: During an observation of a medication pass, conducted on 8/24/2023 at 7:30 A.M., RN 10 washed her hands, took a basket with a glucometer, alcohol swabs, test strips and lancets into Resident 11's room. RN 10 utilized the glucometer to check Resident 11's blood sugar level. After obtaining the resident's blood sugar, the nurse placed the used glucometer back on top of alcohol pads and lancets and placed the basket on top of the medication cart and then placed the whole basket into the medication cart. RN 10 explained she was going to wait until the resident's breakfast tray was delivered before she gave the resident insulin. On 8/24/2023 at 8:00 A.M., RN 10 was observed to sanitize her hands, pull the plastic basket with the used glucometer, alcohol pads and lancets out of her medication cart drawer. She then drew up the dose of insulin for Resident 11. After administering the resident's insulin, the nurse exited the room and observed to wipe the	F 0880	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** **The facility is unable to correct the alleged deficient practice for Resident 11. Resident 11 assessed by Licensed Nurse on 9-5-23 with no negative findings.** **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 receive glucometer checks have the potential to be affected by the alleged deficient practice. DNS/Designee observed glucometer checks of 10 residents on 9-1, 9-12, 9-19 and 9-27 with no deficient practice noted. **3 What measures will be put into place and what systemic changes will be made to**	09/30/2023

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	08/28/2023

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 off quickly with an alcohol prep pad. During an interview with RN 10, on 8/24/2023 at 8:05 A.M., she indicated it was the correct procedure to clean the glucometers with an alcohol prep pad. RN 10 indicated that she wished there was more but that was all they had. RN 10 indicated the glucometer was used for multiple residents on her medication cart. Review of the facility policy and procedure, titled, "Glucometer Disinfection" provided by the Regional Nurse Consultant on 8/24/2023 at 8:50 A.M., included the following: "...1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use...3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 4. Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use...." 3.1-18(a)		**ensure that the deficient practice does not recur: Nursing staff educated by DNS on appropriate cleaning procedures for glucometers by 9-29-23.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DNS/Designee will audit 10 glucometer cleanings weekly X12 weeks then 5 cleanings @12 weeks then 3 cleanings X12 weeks. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the north shower room had shower drains without debris covering them, this had the potential to effect 20 of 20 residents who used the shower room.	F 0921	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**	09/30/2023

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	08/28/2023

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
	Finding includes: On 8/20/23 at 5:58 P.M., the north shower room was observed to have 3 shower heads and drains. The drain the farthest from the entry door had half the drain covered over with hair. The middle drain had a wet empty sugar packet covering 1/4 of the drain. On 8/25/23 at 2:22 P.M., the north shower room was observed and the drain furthest from the entry door had half the drain covered with hair. The middle drain had a piece of the sugar packet lying inside the drain. During a tour of the north shower room, on 8/25/23 at 3:05 P.M., with the Housekeeping Director and the Corporate Administrator from a sister facility, the entry door was observed to have a notice on the door indicating "Floor Wet". The Housekeeping Director indicated the shower room had just been cleaned. The drain furthest from the door was observed with hair covering half the drain and ¼ of a piece of sugar packet was observed on middle drain. The Housekeeping Director indicated the hair debris and sugar packet should of been removed and drain cleaned with daily cleaning of the shower room. A policy was requested but not received, however, a form titled, "North Housekeeper 7:30 AM to 3:30 PM", indicated shower room was part of the housekeepers assignment. The form indicated to begin the day with a walk-through of the assigned area to identify "spills, odors and debris" The form indicated "...Saturdays and Sunday do not clean Social Services Office, North Conf. [Conference] Room, and Library.		The hair and sugar packet was removed from the drain once notified by surveyor by the housekeeper on 8-25-23. **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 use the shower room have the potential to be affected by the alleged deficient practice. Shower rooms observed by ED on 9-29-23 to ensure drains and shower room are clean. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Housekeeping departments in-serviced by Housekeeping corporate to ensure drains are clear when cleaning shower rooms on 9-29-23. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **ED/Designee will audit the shower rooms each business day X12 weeks then 3 times weekly X12 weeks then weekly X12 weeks to ensure shower**	

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	08/28/2023

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
	This Federal tag relates to complaint IN00412401. 3.1-19(4)		**rooms do not have any items in the drain. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.**	