PRINTED: 12/27/2022
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155219	B. W	/2022			
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	AN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	, , , , , , , , , , , , , , , , , , ,	DATE
F 0000							
F 0000 Bldg. 00	IN00391587, IN003 Complaint IN00393 deficiency related to F695. Complaint IN00393 deficiency related to F677. Complaint IN00394 deficiency related to Unrelated deficiency Survey dates: Novo Facility number: 1002 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type Medicare: 5 Medicaid: 55 Other: 2 Total: 62	ember 14, 15, 16, & 17, 2022 00124 155219 266730 ::	F 00	000	We do not submit this plan of correction as admittance or dof the alleged incidents. Plea accept the following as a required for a desk review in lieu of of onsite Post Survey Revisit. A consideration for a desk review ould be much appreciated. There are any additional documents that are needed, please reach out right away.	enial se uest an II	
	accordance with 41	U IAC 10.2-3.1.					
	Quality review com	npleted 11/29/22.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Franklin Ekete

TITLE

Executive Director

12/15/2022

(X6) DATE

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	A. BU	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING (00 B. WING		(X3) DATE SURVEY COMPLETED 11/17/2022	
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A) Reporting of Alleg §483.12(c) In respanse, neglect, exthe facility must: §483.12(c)(1) Ensivolations involvin exploitation or misinjuries of unknown isappropriation reported immedia hours after the allevents that cause or result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established §483.12(c)(4) Reginvestigations to the designated recofficials in accordincluding to the State of the serious of the designated recofficials in accordincluding to the State of the serious of alleged violation is corrective action in the serious of the s	(B)(c)(1)(4) ged Violations conse to allegations of exploitation, or mistreatment, sure that all alleged g abuse, neglect, streatment, including on source and of resident property, are tely, but not later than 2 gegation is made, if the the allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not odily injury, to the the facility and to other to the State Survey protective services where is for jurisdiction in long-term accordance with State law the administrator or his or presentative and to other ance with State law, tate Survey Agency, within the incident, and if the is verified appropriate must be taken.					
	failed to report and residents reviewed	view and interview, the facility allegation of abuse for 1 of 3 for abuse. (Resident K)	F 06	509	F 609 Reporting of Alleged Violations. 1. What corrective action		12/15/2022
	Finding includes: On 11/15/2022 at 1	1:30 A.M. a phone call was			will be accomplished for tho residents found to have bee affected by the deficient		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155219	B. W	NG		11/17/	/2022
				CED FIELD	ADDRESS OF A STATE OF COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
MA IECT		LLDEND			N IRONWOOD RD		
MAJESTIC CARE OF SOUTH BEND			SOUTH	I BEND, IN 46635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	received from the C	Ombudsman. She indicated she			practice;		
	was looking into a 9	911 phone call placed from a					
	resident at the facility. She indicated she was				a. ED and DNS were		
		from the facility. She indicated			educated on the abuse policy	by	
	she had visited the	facility on Monday/Tuesday			the Regional Nurse Consultan	t	
	of last week and talked with Resident K. Resident				and Regional Vice President o	of	
		ed to her that a night nurse had			Operations which includes		
	argued with her and pulled her phone out of her				reporting, time frame of report	_	
	hand and hurt her hand. The Ombudsman				and the investigation process.		
	indicated she had communicated the allegation to				b. Education of ED, DNS, a	and	
	the Administrator. She stated the Administrator				all facility staff on Preventing,		
	indicated the resident's phone was not working				Recognizing, and Reporting		
	and the resident had called 911, but there was no				Abuse.		
		adsman indicated she had			c. Resident A was assesse		
	-	ninistrator if the alleged			and had no negative psychoso		
	_	ed to the state, which he		outcomes, all abuse allegations			
		te things up, but the reports			were investigated and reported to		
		r of Nursing's office and it was			IDOH per policy.		
		dsman asked for the report to					
		The Ombudsman indicated she			2. How other residents		
		ty after talking with the			having the potential to be		
		was put through to the Social			affected by the same deficier		
		Social Service staff indicated to			practice will be identified and		
		e had the reports in a binder			what corrective action(s) will		
	and they are always				be taken;		
		ted she still had not received			a. All residents have the		
	any state report of t	he allegation as of 11/15/2022.			potential to be affected by the		
	D	11/15/2022 - 11 20 4 34			deficient practice. (Resident K	.)	
		v, on 11/15/2022 at 11:30 A.M.,			b. All residents were		
		ed she had an accident a week			interviewed by ED/ DNS or		
		rse. She indicated she usually d and the window cracked in			designee regarding any conce		
	_				or allegations that may need to	o be	
		tilation in her room. On Sunday			investigated and/or reported.		
	_	closed she had put on her call open up her door. She			3. What measures will be		
	_						
		relling and screaming to get			put into place and what	do	
	_	she could not breathe and emen and medical staff came in			systemic changes will be ma	iue	
		and the staff and had			to ensure that the deficient		
		clean me up. After they had			practice does not recur;	toff	
	msu ucted them to c	hean me up. Arter they had	1		 a. Abuse education of all st 	lali	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155219 11/17/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE left, Resident K indicated the nurse came back to was completed by ED/ DNS and her room and grabbed her phone away from her so will be an ongoing every 6months she could not call 911 again. Resident K indicated and as needed. the nurse "physically fought me" for the phone and ended up getting it away from her. Resident K 4. How the corrective indicated she had skinned up her finger on the action(s) will be monitored to right hand when it happened and had talked with ensure the deficient practice the Administrator on Monday and informed him will not recur, i.e., what quality of what had happed. Resident K indicated the assurance program will be put Administrator stated he would try to find the into place; phone and who it was who took the phone. QAPI tool Abuse will be completed weekly X4, bi-weekly x During an interview, on 11/15/2022 at 11:55 A.M., 2 and monthly X4 by ED. If 100% the friend listed on Resident K's chart, indicated threshold is not achieved, an he "had only received 2 phone calls on Monday action plan will be developed. This the 7th. First call was from EMS and the second information will be presented to one from the facility. "He indicated he had asked the QAPI committee during the what had happened, but was not given any monthly meeting. information. He indicated he visited the facility on Monday 11/7/2022 and talked with the The ED is responsible for Administrator. The friend stated the ensuring implementation of the "Administrator communicated to him they were plan of correction and that investigating it and would try to verify if an aide compliance is maintained. or someone did abuse her". By what date the systemic During an interview, on 11/15/2022 at 12:09 P.M., changes for each deficiency the Administrator indicated if there was an will be completed. allegation of abuse he would send the staff home 12/15/2022 immediately, get statements by the staff, do a resident assessment, interview residents and staff who were working and up date the care plans. A list of reportable's from the past 6 months was requested on 11/15/2022. No reportable regarding the alleged incident occurring on 11/7/2022 for Resident K was provided. During an interview, on 11/16/2022 at 2:39 P.M., the Administrator indicated he did not report anything on Resident K for the phone issue. He

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLETED			ETED
		155219	B. W	ING		11/17	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			N IRONWOOD RD		
MAJESTIC CARE OF SOUTH BEND				BEND, IN 46635			
				<u> </u>			T .
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		een informed of the residents					
		and the staff had put in a					
	_	st for the phone and there was					
		indicated he was not aware of					
	-	ouse from the nurse. The					
		cated that was not the					
		given by the Ombudsman					
		ed on Monday or Tuesday last					
		strator indicated he should have					
	_	leged incident and reported it					
	to the state.						
	0 11/16/2022 + 2	01DM 4 A1 '''					
	On 11/16/2022 at 3:01 P.M., the Administrator provided the policy titled," Abuse Prevention						
	-	arch 2021, and indicated the					
		currently used by the facility.					
		ed"Employees, facility					
		attending Physician's must					
		any suspected abuse or to the Administrator When					
		cted (reasonable cause) case					
		eglect, exploitation, injuries of					
		r abuse is reported, the facility					
		N, or individuals designated					
	· ·	not to exceed 24 hours if the					
		ilt in serious bodily injury). No					
		f the event is an allegation of					
		re is significant injury, or					
		e is serious bodily injury) notify					
	-	ons or agencies of such					
		ate licensing/certification					
		artment of Aging) responsible					
		sing the facility; 2. The					
		ntative (Sponsor) of Record"					
	resident's represen	mative (Sponsor) of Record					
	3.1-28(c)						
F 0610	483.12(c)(2)-(4)						
SS=D		nt/Correct Alleged Violation					
Bldg. 00	_	ponse to allegations of					

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155219	B. WING 11/17/20			/2022	
				CTDEET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	10 04 DE 05 00UT	CLIDEND			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H REND		SOUTH	H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	abuse, neglect, exploitation, or mistreatment,						
	the facility must:						
	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while						
	the investigation is	s in progress.					
	-						
	§483.12(c)(4) Rep	oort the results of all					
	investigations to the administrator or his or						
	her designated re	presentative and to other					
	officials in accorda	ance with State law,					
	including to the St	ate Survey Agency, within					
	5 working days of	the incident, and if the					
	alleged violation is	s verified appropriate					
	corrective action r	nust be taken.					
	Based on interview	, and record review, the facility	F 06	510	F 610		12/15/2022
	failed to investigate	an allegation of abuse for 1 of			Investigate, Prevent, and		
	3 residents reviewe	d for abuse. (Resident K)			Correct Alleged Violations.		
					1. What corrective action(s)	will	
	Finding includes:				be accomplished for those		
					residents found to have beer	n	
	On 11/15/2022 at 1	1:30 A.M., a phone call was			affected by the deficient		
		Ombudsman. She indicated she			practice;		
	_	911 phone call placed from a					
		ity. She indicated she was			a. ED and DNS were		
		from the facility. She indicated			educated on the abuse policy	-	
		facility on Monday/Tuesday			the Regional Nurse Consultan		
		ked with Resident K. Resident			and Regional Vice President of	of	
		ed to her that a night nurse had			Operations which includes		
		l pulled her phone out of her			reporting, time frame of report	•	
		and. The Ombudsman			and the investigation process.		
		ommunicated the allegation to			b. Education of ED, DNS, a	and	
		She stated the Administrator			all facility staff on Preventing,		
		nt's phone was not working			Recognizing, and Reporting		
		d called 911, but there was no			Abuse.		
		idsman indicated she had			c. Resident A was assesse		
	questioned the Adn	ninistrator if the alleged	1		and had no negative psychoso	ocial	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/17/2022 155219 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE incident was reported to the state, which he outcomes, all abuse allegations replied they do write things up, but the reports were investigated and reported to were in the Director of Nursing's office and it was IDOH per policy. locked. The Ombudsman asked for the report to be emailed to her. The Ombudsman indicated she How other residents had called the facility after talking with the having the potential to be Administrator and was put through to the Social affected by the same deficient Service staff. The Social Service staff indicated to practice will be identified and the Ombudsman she had the reports in a binder what corrective action(s) will and they are always in her office. The be taken; Ombudsman indicated she still had not received All residents have the any state report of the allegation as of 11/15/2022. potential to be affected by the deficient practice. (Resident K) During an interview, on 11/15/2022 at 11:30 A.M., All residents were Resident K indicated she had an accident a week interviewed by ED/ DNS or ago with a night nurse. She indicated she usually designee regarding any concerns had the door opened and the window cracked in or allegations that may need to be order to get air ventilation in her room. On Sunday investigated and/or reported. night, the door was closed she had put on her call light for someone to open up her door. She What measures will be indicated she was yelling and screaming to get put into place and what help. She indicated she could not breathe and systemic changes will called 911. The firemen and medical staff came in be made to ensure that the and talked with her and the staff and had deficient practice does not instructed them to clean me up. After they had Abuse education of all staff left, Resident K indicated the nurse came back to her room and grabbed her phone away from her so was completed by ED and will be she could not call 911 again. Resident K indicated ongoing every 6months and as the nurse "physically fought me" for the phone needed. and ended up getting it away from her. Resident K indicated she had skinned up her finger on the How the corrective right hand when it happened and had talked with action(s) will be monitored to the Administrator on Monday and informed him ensure the deficient practice of what had happed. Resident K indicated the will not recur, i.e., what quality Administrator stated he would try to find the assurance program will be put phone and who it was who took the phone. into place; QAPI tool Abuse will be During an interview, on 11/15/2022 at 11:55 A.M., completed weekly X4, bi-weekly the friend listed on Resident K's chart, indicated X2, and monthly X4 by ED. If

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he "had only received 2 phone calls on Monday

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100% threshold is not achieved,

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provided the policy titled," Abuse Prevention Program", dated March 2021, and indicated the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/17/2022				
	PROVIDER OR SUPPLIER		52654	STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
F 0677 SS=D Bldg. 00	policy was the one of The policy indicated consultants and/or a immediately report incidents of abuse to an alleged or suspect of mistreatment, negunknown source, or Administrator, DON will immediately (revent does not resultater than 2 hours if abuse or where there the following person incident: 1. The Staragency (Ohio Depart for surveying/licens Resident's Representatives and the surveying states of the surveying states and the surveying states are carry out activities necessary service nutrition, grooming hygiene; Based on observation interview, the facility who were incontine odor free for 2 of 4 incontinence care. (Findings include: 1. During an observer the policy includes of the survey of the facility who were incontine odor free for 2 of 4 incontinence care. (Findings include: 1. During an observer P.M., Resident G.W.	currently used by the facility. d"Employees, facility ttending Physician's must any suspected abuse or to the Administrator When sted (reasonable cause) case glect, exploitation, injuries of abuse is reported, the facility N, or individuals designated not to exceed 24 hours if the t in serious bodily injury). No the event is an allegation of the is significant injury, or is serious bodily injury) notify as or agencies of such te licensing/certification rement of Aging) responsible ing the facility; 2. The tative (Sponsor) of Record" d for Dependent Residents esident who is unable to of daily living receives the s to maintain good g, and personal and oral on, record review and ty failed to ensure residents int were kept clean, dry and residents reviewed for	F 0677	F 677 ADLs Provided for Dependen Residents 1. What corrective action(swill be accomplished for those residents found to have been affected by the deficient practice; a. Education of all nursing son Quality of Care for all reside especially regarding ADLs.	12/15/2022 t staff			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
ANDIEM	or conduction	155219	B. WING	<u> </u>	11/17/2022			
			CTREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIE	R		N IRONWOOD RD				
MAJEST	IC CARE OF SOU	TH BEND	SOUTH BEND, IN 46635					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE			
	indicated the pants	s were wet.		b. Full facility audit of all				
				dependent residents who are				
		n 11/14/2022 at 12:30 P.M.,		unable to carry out activities of	f			
		area extended from the peri area		daily living.				
	to the middle of he	er thighs.		c. Increased rounding by				
		44/44/9000		facility utilizing Daily Qapi tool.				
	An observation, on 11/14/2022 at 1:50 P.M.,			d. Neither G or H had any				
		rea extended further down her		negative outcomes and no ski	n			
	thighs almost to he	er knees.		issues noted.				
	An observation, on 11/14/2022 at 3:45 P.M.,			2. How other residents				
		area extended from her waist to		having the potential to be				
	her knees.			affected by the same deficier	nt			
				practice will be identified and	 			
	A clinical record re	eview was completed for		what corrective action(s) will				
		14/2022 at 2:17 P.M.		be taken;				
				a. All residents have the				
	Diagnoses include	d, but were not limited to,		potential to be affected by the				
	Paranoid Schizoph	renia, Bipolar Disorder, Major		deficient practice. The IDT tea	m			
	Depressive Disord	er, and Alzheimer's Disease.		reviewed and audited all				
				dependent residents with ADL				
		Assessment dated 10/3/2022		needs.				
		ssist of 1 for transfers, extensive		b. Full facility audit of all				
		ting and personal hygiene, is		dependent residents who are				
	1 -	t of bladder, and frequently		unable to carry out activities of	f			
	incontinent of bow	el.		daily living.				
		11/01/0000		c. Increased rounding by				
		1 1/21/2022, indicated a problem:		facility utilizing Daily Qapi tool.				
	_	isodes of incontinence of						
		nterventions included, but were		3. What measures will be				
		st with routine toileting and as		put into place and what	مام			
		tinely for incontinence, and use care as needed"		systemic changes will be ma	ue			
	provide incommen	ice care as heeded		to ensure that the deficient practice does not recur;				
	A Care Plan dated	1 10/19/21, indicated:		a. IDT team and managers	ς,			
	1	assistance with activities of		daily rounds which will be revie				
		to Dementia, Alzheimer's,		and audited weekly x4, bi-wee				
		renia, Major Depressive		x2, and monthly x3.	,			
	_	nsion. Interventions included,		A., and monthly No.				
		ed to, continence - assist with		4. How the corrective				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			COMPLETED
		155219	B. WING 11/17/2022			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD	
					N IRONWOOD RD	
MAJESTIC CARE OF SOUTH BEND			SOUTH	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	incontinent care; to	ilet use- limited assist of x1			action(s) will be monitored to	o
	staff. Staff to provid	de additional support as			ensure the deficient practice	
	needed"				will not recur, i.e., what quali	ity
					assurance program will be p	-
	An ADL (Activities	s of Daily Living) Task sheet			into place;	
	indicated, on 11/13/2022, Resident G was toileted				a. Weekly Qapi by the IDT	•
	at 2:04 A.M.				team to review and audit weel	
					x4, bi weekly x2, and monthly	x3.
	The ADL Task sheet indicated, on 11/14/2022, the				5. Who is the "Team" that	
	resident was toilete	d at 1:58 A.M. and 9:59 P.M.			will review and audit? Who	
	The ADL Task sheet indicated, on 11/15/2022, the				will oversee that the "Team"	is
					conducting the audits and	
	resident was toileted at 1:25 A.M. and 12:46 P.M.				reviews as pledged?	
					a. All reviews and audits w	vill
	The ADL Task shee	et indicated, on 11/16/2022, the			be completed by the IDT team	١.
	resident was toilete	d at 4:28 A.M., 12:44 P.M., and			The ED/ DNS followed by the	
	7:38 P.M.				MDS, SSD, Therapy Director,	and
					Unit Manager will ensure that	all
	During an interview	v, on 11/17/2022 at 3:30 P.M.,			audits and reviews are comple	eted
	CNA 10 indicated t	hat she toilets Resident G			accurately and promptly.	
		and just toileted her and				
		oyee indicated that at times			6. By what date the syster	mic
		, but usually, if you talk calmly,			changes for each deficiency	
	the resident will all	ow care.			will be completed.	
					a. 12/15/2022	
	_	vation, on 11/15/2022 at 11:50				
		vas observed sitting in the hall				
		ses' station with a strong urine				
	odor and wetness to	the peri area.				
		11/15/2020 11 52 73 7				
		ion, on 11/15/2022 at 1:53 P.M.,				
		served sitting in the hall across				
		tion with a strong urine odor				
	and a linen napkin	covering her lap.				
	A 1' ' 1 ' 1					
		view was completed on				
		P.M. Resident H's diagnoses				
		not limited to: Dementia,				
	hypertension, arthri	itis, and depression.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>	COMPLETED
155219 B. WING	11/17/2022
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND STREET ADDRESS, CITY, STA 52654 N IRONWOOD R SOUTH BEND, IN 4663:	RD
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROJUDENCE	(X5)
PROVIDERS H	LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIATE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFI	ICIENCY) DATE
A Quarterly MDS (Minimum Data Set)	
Assessment, dated 7/27/2022, indicated the	
resident required extensive assist of 2 staff for	
transfers and 1 staff for toilet use and was	
occasionally incontinent of bladder.	
A current care plan, dated 7/8/2020, indicated	
Resident H required staff assist with ADL's	
(activities of daily living). Interventions included	
but were not limited to:	
Toilet use: Limited assist, Staff to provide	
additional assistance as needed.	
During an observation, on 11/15/2022 at 3:58 P.M., Resident H was observed sitting in the hall across from the nurses' station with a strong urine odor and a linen napkin covering her lap.	
On 11/14/2022, at 3:43 P.M., the Director of	
Nursing was asked to remove the napkin from	
Resident H's lap. A large wet area to the resident's	
peri aera and extending down the pant legs was	
observed.	
During an interview, on 11/15/2022 at 3:44 P.M., the Director of Nursing indicated that Resident H should have been checked and changed every 2 hours. The Director of Nursing sought out the aide responsible for the resident and indicated the resident needed care immediately.	
On 11/17/2022, at 9:45 A.M., the corporate nurse provided a copy of a clinical protocol titled,	
"Urinary Incontinence - Clinical Protocol." The	
protocol indicated, " As appropriate, based on	
assessment of the category and causes of	
incontinence, the staff will provide scheduled	
to ileting, prompted voiding, or other interventions to try to improve the individual's continence	
status"	

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Event ID:

RCZZ11 Facility ID: 000124

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2022				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	provided a copy of a Incontinence - Asse The policy indicated will appropriately so individuals with urit policy also indicated respond and does not with such severe concannot either point to name, staff will use" The policy furth change' strategy invocontinence status at incontinence device goals are to maintain protect the skin" 3.1-9(a)	a policy titled, "Urinary ssment and Management." d, "The staff and practitioner creen for, and manage, nary incontinence" The d, "If the resident does not of try to toilet, or for those gnitive impairment that they to an object or say their own a 'check and change' strategy ner indicated, "A 'check and olves checking the resident's regular intervals and using so or garments. The primary in dignity and comfort and to					
F 0695 SS=E Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care is provided such of professional stand comprehensive pet the residents' goal 483.65 of this sub Based on observation	e and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, is and preferences, and	F 0695	F 695 Respiratory/ Tracheostomy Care and Suctioning	12/15/2022		

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Event ID:

RCZZ11 Facility ID: 000124

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) Da		(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155219	B. WI	ING		11/17	/2022
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8					
MA IESTI	IC CARE OF SOUT	L REND	52654 N IRONWOOD RD				
IVIAJESTI				30018	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	identified by oxyge	n signs for 10 of 12 resident			1. What corrective action(s)	
	rooms observed wit	h oxygen. (Residents E, K, L,			will be accomplished for thos	se	
	M, R, Q, U, V, W,	and X)			residents found to have beer	า	
					affected by the deficient		
	Findings include:				practice;		
					a. Resident rooms where		
	1. During an initial	tour of the South hall with RN			oxygen was being used/ store	d	
	4, on 11/14/2022 fro	om 10:16 A.M. to 10:45 A.M.,			were properly identified with		
	the following was o	bserved:			oxygen signs immediately upo	n	
	Room 101A: an oxy	ygen tank was sitting on the			finding.		
floor along the wall. RN 4 indicated the Resident K				b. Education of all nursing	staff		
	used oxygen routing	ely.			on Respiratory Care to ensure	;	
					proper handling and identificat	tion	
	Room 102A: an oxy	ygen concentrator in the room.			of resident rooms utilizing oxy	gen.	
	RN 4 indicated Res	ident L used oxygen PRN (as					
	needed).				2. How other residents		
					having the potential to be		
	Room 103B: an oxy	gen concentrator in the room.			affected by the same deficien	nt	
	RN 4 indicated Res	ident R used oxygen PRN.			practice will be identified and	d	
					what corrective action(s) will		
	Room 106B: an oxy	gen concentrator was being			be taken;		
	used. RN 4 indicate	d Resident M used the oxygen			a. All residents have the		
	routinely.				potential to be affected by the		
					deficient practice. The nursing		
		ygen concentrator was in use.			management team audited all		
	RN 4 indicated Res	ident Q used the oxygen			resident rooms to ensure that		
	routinely.				oxygen room signages are pla	iced	
					appropriately.		
		ygen concentrator was in use.					
		ident E used the oxygen			3. What measures will be		
	routinely.				put into place and what		
					systemic changes will be ma	de	
	_	tour of the North hall with			to ensure that the deficient		
		edication Aide) 2 from 10:47			practice does not recur;		
	A.M. to 11:02 A.M	., the following was observed:			a. The IDT team will review	V	
					and audit resident rooms to		
		ygen concentrator in the room in			identify the ones utilizing oxyg	en	
	*	ed Resident U used the			weekly x4, bi weekly x2, and		
oxygen routinely.				monthly x3.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155219	B. WI	B. WING		11/17/2022	
		1	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND			BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ygen concentrator in the room			4. How the corrective		
		cated Resident V used the			action(s) will be monitored to)	
	oxygen as needed.				ensure the deficient practice		
					will not recur, i.e., what quali	ty	
	Room 212: an oxygen concentrator and a CPAP				assurance program will be p	ut	
		e airway pressure) machine in			into place;		
	the room. QMA 2 indicated Resident W used the				a. The IDT team will utilize		
	oxygen PRN.				Qapi audit tool to review and a		
					resident rooms to identify the	ones	
		gen concentrator in the room in			using oxygen weekly x4, bi		
	use. QMA indicated routinely.	d Resident X used the oxygen			weekly x2, and monthly x3.		
	-				5. Who is the "Team" that		
	During an interview	v, on 11/16/2022 at 3:20 P.M.,			will review and audit? Who		
	the Director of Nurs	sing indicated if residents were			will oversee that the "Team"	is	
	using oxygen, they	should have an 02 sign on the			conducting the audits and		
	door.				reviews as pledged?		
					a. All reviews and audits w	/ill	
	On 11/17/2022 at 9	:45 A.M., the Corporate Nurse			be completed by the IDT team	١.	
	provided the policy	titled," Oxygen			The ED/ DNS followed by the		
		ith a revision date of October			MDS, SSD, Therapy Director,	and	
	2010, and indicated	the policy was the one			Unit Manager will ensure that	all	
	currently used by th	ne facility. The policy			audits and reviews are comple	eted	
		nent and Supplies4. "No			accurately and promptly.		
	Smoking/Oxygen in	n Use" signs"					
					6. By what date the syster		
	3.1-47(a)(6)				changes for each deficiency		
					will be completed.		
					a. 12/15/2022		
	This Federal tag rel	ates to Complaint IN00391587.					

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