STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	08/16/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387518 and IN00387579. Complaint IN00387518 - Substantiated. Federal/State deficiencies related to the allegations are cited at F742. Complaint IN00387579 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 15 and 16, 2022 Facility number: 000476 Provider number: 155446 AIM number: 100290870 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 7 Medicaid: 63 Other: 8 Total: 78 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 18, 2022.	F 0000		
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-			

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

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

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	§483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review, the facility failed to ensure a behavioral plan was developed and implemented for 1 of 1 residents reviewed (Resident C). Findings include: On 8/15/22 at 11:25 A.M., Resident C's record was reviewed. Diagnoses included diabetes, pressure ulcers to coccyx and foot, chronic pain syndrome, and somatoform disorder (mental disorder with multiple recurring physical symptoms, including pain, that can't be explained by a medical condition). An admission MDS (Minimum Data Set) assessment, dated 5/9/22, indicated the resident had a BIMS (Brief Interview Mental Status) score of 15 (no cognitive impairment). A PHQ-9 (9 item patient health questionnaire to screen for symptoms of depression) indicated she had multiple mood indicators as follows: trouble falling asleep, feeling tired and having little energy, poor appetite, trouble concentrating, fidgety and restless, having thoughts would be better off dead and hurting herself. Her PHQ-9 was scored at a value of 20. This indicated she had severe depressive symptoms. The assessment indicated she had no behaviors and required extensive assistance from staff with her activities of daily living including locomotion on the unit using a	F 0742	F742 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C's behavioral care plan has been reviewed and revised as indicated on 9/1/2022 by the Interdisciplinary Team. Resident C was referred to pain management on 8/11/2022. Resident C was assessed and deemed unsafe to utilize a motorized wheelchair on 9/2/2022 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; Residents that reside in the facility with the need for a behavioral care plan have the potential to be affected by the alleged deficient practice. All behavioral care plans were	09/02/2022

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	wheelchair. She complained of constant severe pain daily which limited her day to day activities. She was prescribed anti-depressant medication as well as routine pain medications. A review of Care Area Assessments (CAA), dated 5/9/22, indicated the following: 1. Pain-Resident C was at risk for pain due to decreased mobility and heart failure, diabetes and depression. She had a diagnosis of chronic pain and was on scheduled opioid medications. The licensed nurse was to assess pain routinely, as needed and notify the provider if pain was unrelieved with medications. The resident was able to communicate her pain and need for pain medication. The NP/MD (Nurse Practitioner/Medical Doctor) were aware of her current medications/diagnoses and had ordered a referral to pain management. 2. ADL-the resident required extensive to total assistance with her ADL's affected by her mood and depression. She was cooperative with care and was able to use a wheelchair with staff assistance. Orders were in place for referral to pain management and psychiatric services. 3. Mood State-the resident indicated she'd had issues at her previous nursing facility and had been anxious to come to this facility. 4. Psychotropic medication- the resident was receiving an anti-depressant for depression and was at risk for side effects. She was referred to psychiatric services for evaluation and treatment. Somatic disorder was not addressed in the CAAs. Care plans indicated the following: - Resident C had chronic pain. The goal was for her to verbalize adequate relief of pain. Interventions included administer medications as ordered; notify MD of unrelieved or worsening		audited on 9/1/ Social Services/Designee to ensure proper interventions are in place. 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 was educated on hire by the home office Director of Social Services on implementing behavioral care plans. All staff was educated on 9/1/2022 by the DNS/Designee on behavior management and interventions. 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; QAPI tool Behavioral Health will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. is requesting desk review.	

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	pain; observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM or resistance to care; observe for side effects of pain medication-constipation, new onset or increased agitation, restlessness, confusion, nausea, vomiting, dizziness and falls; report to the physician; offer non-pharmacological interventions; therapy to screen quarterly and as needed. - Resident C was at risk for alterations in mood and depression symptoms with a goal of having an improved mood state as well as decreases in the frequency of mood symptoms. Interventions included, but were not limited to: behavioral health consults as needed; notify behavioral health specialists of changes or no improvement in resident's mood; encourage resident to express feelings; assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. - The resident could become agitated and irritable with behaviors of yelling, screaming, abusive language, calling staff names and using her motorized wheelchair to corner staff and attempt to hit them. The goal was for the resident to demonstrate effective coping skills related to her behaviors. Interventions included, but were not limited to, allow resident to vent her feelings and discuss effective coping techniques; remove her from over stimulating areas; approach her in a calm and friendly manner; if she becomes combative or resistive, postpone care and allow her to regain her composure and reapproach; listen to her needs and adjust plan as appropriate; maintain a safe environment for resident; review for potential safety risk regarding use of motorized wheelchair; supply regular/manual wheelchair and therapy to continue to review.			

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	Somatic disorder was not addressed in the care plans. On 8/15/22 at 1:18 P.M., Resident C was interviewed and observations were made. The interview was conducted in an empty room per the resident's request. She was seated in a wheelchair with her right foot resting on the wheelchair pedal. She had a purse with her and proceeded to pull out papers, dated years prior. The papers indicated she wasn't to be in a regular wheelchair, she was to be in a motorized chair. This was a big concern for her. She indicated the facility had removed her motorized chair without cause and put her into a manual wheelchair she couldn't propel easily herself. She was observed to have her right hand bandaged with a black glove partially covering the bandage. She indicated she had rubbed the skin off her hand while trying to propel the wheelchair herself. Her left hand appeared arthritic with nodules around the joints of her fingers and she was missing part of her left thumb. As she spoke, she made several attempts to remove the top of her ice cream cup with her hands which took much time and effort due to being unable to grasp the lid of the cup with her fingers. She indicated several other concerns with the facility including issues with adequate pain relief for chronic pain. She had been on the same pain management regimen for several years and didn't understand why now she had to see pain management because the NP here at this facility wasn't comfortable prescribing them. She indicated staff didn't want to help her. She indicated there had been an incident where staff had entered her room and had taken some cough medicine she'd had in a box on her dresser during the middle of the night. She had become so angry she had gotten into her wheelchair and went to			

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	the nurse station where staff sat with chairs barricaded around them. She rammed her motorized chair into the chairs to scare them because she felt they shouldn't have taken things from her room. She indicated she had been a nurse for several years and had never seen patients treated the way she's been treated. A review of progress notes indicated the following: -NP note: 5/3/22 at 4:36 p.m., the resident was seen for new admission to the facility. Resident C indicated she'd been under increased amounts of stress and was agitated during the visit. She was being treated with an anti-depressant medication and was prescribed pain medication per hospital discharge instructions. The resident denied being followed by pain management for chronic pain. She was placed at the facility for rehabilitation and noted by the hospital to have numerous comorbidities. The conditions and chronic care needs created challenges for her. Assessment: chronic pain syndrome; resolved urinary tract infection (UTI), and psychosomatic disorder. The plan was for psychiatric services to evaluate and treat as well. Her anti-depressant medication was increased from 20 milligrams (mg) to 40 per day. -NP note: 5/13/22 at 6:13 a.m., the resident had requested to have hydromorphone (pain medication) routine versus on an as needed schedule. She was to be referred to pain management. She also requested a different seasonal allergy medication. This was ordered. The plan was to change hydromorphone to 2 mg by mouth every 4 hours, refer to pain management, refer to psychiatric services, and change allergy medication. - 5/13/22 at 1:08 p.m., the resident had been cursing at staff and had excessive call light use. -5/16/2022 at 10:37 a.m., the nurse spoke with the			

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	resident about getting an appointment with pain management and the resident indicated she would not go to pain management. She indicated she only needed to take 1 hydromorphone 2 mg tab in the morning and evening and a PRN dose if needed. The NP was to be notified. -NP note: 5/17/22 at 9:57 p.m., indicated the resident was requesting the NP to prescribe her pain medications. The NP indicated she was not comfortable perscribing the medications. The resident hadn't wanted pain management because she hadn't believed it was necessary and she was stable on her current medication regimen. The NP indicated she would continue with the current medications until palliative care or pain management was consulted. The resident had been alert but agitated during the visit, had indicated there were several medications she was allergic to and couldn't take therefore she believed her current pain medications were appropriate. She rated her current pain at a 8 out of 10 with 10 being the worst pain. The plan indicated psychiatric services were following her and an order would be given for either palliative care or pain management. -NP note: 5/30/22 at 9:14 a.m., the resident complained of right ear pain ongoing the past several days along with a sensation of fluid behind her eardrum. The plan was for an antibiotic to be given 2 times per day for 5 days and to continue with psychiatric services. -6/3/22 at 11:36 a.m., the resident was rude, called the nurse stupid and yelled at staff for no reason. - 6/3/22 at 1:44 p.m., she was up at the front desk yelling because staff wouldn't help her immedicately as it was their job. -6/7/22 at 9:08 a.m., she yelled at the Administrator to come and speak with her. When the Administrator did so, the resident was irate, angry, believed staff were treating her badly and			

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	the Administrator hadn't done anything about it. She complained of an ear ache, excruciating pain in her right hip and a UTI (urinary tract infection). -At 11:36 a.m., the DON (Director of Nursing) spoke with the resident, she complained she was in pain, her ear hurt and she needed her urine checked for a UTI. The NP was to be notified. -At 2:10 p.m., the NP saw the resident who complained of continued ear pain despite recent treatment with an antibiotic. Her ear canal and eardrum were without redness, swelling or tenderness. She was prescribed another antibiotic 1 time per day for 5 days for mastoiditis (infection of bone behind ear) and oral steroids for 5 days. She was to continue with psychiatric services. -NP note: 6/14/22 at 10:35 p.m., the resident complained of urinary frequency, pain with urination and back pain along with other multiple complaints. Her pain medications were to be decreased per the resident's request and the facility was waiting on response for palliative care. The plan was to send a urine sample to the lab, decrease her pain medication to 3 times daily, continue with current medications and psychiatric services were to continue following. -6/17/22 at 9:31 a.m., new orders were gotten for the resident's complaint of UTI symptoms. An in-house urine dip was positive, her urine was sent out to the lab for culture and sensitivity. She was prescribed another antibiotic to be given 2 times per day for 7 days for UTI. -6/30/22 at 11:22 p.m., at the beginning of the shift, the resident had been yelling at staff and cursing because she said she hadn't received her medication. The allegation of not receiveing her mdications was not verified. -7/3/22 at 8:28 p.m., the resident was yelling at the 2 CNA's working with her. The resident told the aides they weren't working fast enough and were being mean to her. She told the aides they worked			

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	for her and had to do what she said. -NP note: 7/6/22 at 8:14 a.m., the resident was seen for a routine visit. She complained of some chest heaviness and believed she was developing pneumonia. She had been on several antibiotics the last month. She was also concerned that she may have a UTI. She complained of diarrhea and agreed to a stool culture. She had been seen by Orthopedics for her right hip pain and had been told she had bone spurring and osteoarthritis. She was to be seen by pain management with orthopedics for further evaluation and treatment with steroid injections. The plan was to obtain a chest x-ray, complete lab work in the morning, obtain stool culture and urinalysis, and get a COVID test. At 5:59 p.m., the resident yelled at staff for bringing in her medication and woke her up to take it after she'd had the call light on and had requested the medication. -NP note: 7/8/22 at 10:22 a.m., the resident was seen for multiple complaints. A stool culture showed she was positive for C. diff , was to be treated with an antibiotic for 10 days and was in isolation. She was prescribed an antibiotic 3 times per day for 10 days and a probiotic for 30 days. -7/13/22 at 3:30 p.m., the resident had been to the DON's office with complaints. She went back down to her hallway and demanded the nurse help her immediately. The resident blocked the nurse from getting to her medication cart. She was assisted and later in the evening, again demanded staff help her immediately, then became more and more agitated. When staff went to put her to bed, she screamed, yelled and cursed at staff. The nurse instructed the staff to leave and return once the resident calmed down. The resident got herself out of bed, into her motorized chair, came down the hallway and chased after staff. She ran over a CNA's (Certified Nurse Assistant) foot and			

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	attempted to run into other staff including the nurse. She rammed the medication cart with her chair and tried to block the nurse from getting to the cart. The resident eventually calmed down and was assisted to bed. According to the nurse, the resident was using her motorized chair to threaten staff and bully them into getting her way. At 8:45 p.m., an NP note indicated the resident had been seen for multiple medical complaints. The resident had been upset about her current medications. She wanted her pain patch discontinued and didn't want to take her diuretics as ordered. She was frustrated about her pain medications and wanted more of the hydromorphone prescribed. The residents pain patch was discontinued and a muscle relaxant prescribed per the resident's request. Psychiatric services were to continue seeing the resident. -7/25/22 at 5:49 a.m., the resident was found with unsecured cough medication in her room. The medication was removed by the nurse. The resident became angry, got into her motorized wheelchair, went to the nurses station where she backed the nurse and CNA into a corner, tried to hit staff, cursed and yelled at staff. The police were called who were able to calm her down and assist her back to her room. -7/27/22 at 3:38 p.m., the Social Services Consultant, Administrator and DON attempted to speak with the resident about her behaviors toward staff. She was very angry, agitated, and yelled and screamed. She refused to listen to anything said to her. She was asked to review a behavior contract which she refused. She refused a care plan conference to discuss her care. She was not receptive to attempts at discussing the facility policy for keeping medications in her room, indicated she was a nurse and could take cough syrup on her own. She was told for her safety, that of the staff and other residents, her motorized			

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	chair was going to be replaced with a manual wheelchair. At 5:45 p.m., a chest x-ray report indicated the resident had pneumonia and was prescribed an antibiotic 2 times per day for 7 days. -NP note: 7/29/22 at 4:49 a.m., indicated the resident had been seen for multiple medical complaints. A recent chest x-ray had been completed due to increased shortness of breath. The x-ray showed pneumonia and she was started on an antibiotic. The resident complained of stomach pain and pain in her hands from use of a manual wheelchair. Her motorized chair had been taken away due to her hitting staff with her chair. Nursing staff reported the resident had been refusing her medications except her pain medications. The plan was for the resident to see pain management for evaluation and treatment, continue antibiotics for 10 days, encourage resident to take her medications, and recommend covering her hand to prevent skin breakdown. -8/1/22 at 7:20 p.m., the resident went to the DON and Administrators offices and banged on their closed doors. The resident wheeled herself into the DON's office after the door was opened, immediately began yelling, cursing about staff, and alleged nobody does anything for her. The resident told the DON she wasn't leaving her office until she got back her motorized chair and it was explained again why returning the chair wasn't possible currently. Another staff member intervened and was able to redirect her to go back to her room with her where she then calmed down. At 8:30 p.m., she made statements to the CNA she was going to starve herself to death and hurt herself until she left the facility on a stretcher. She complained of pain and was very agitated. Emergency services were notified and she was transported to the hospital.			

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	A hospital discharge note, dated 8/2/22, indicated the resident had been seen for health issues that were getting out of control. She complained of pain in her hand, right leg pain, and dull chest pain. While hospitalized, she complained about the facility staff and the care received. She was seen by behavioral health and determined to not require inpatient psychiatric services at the time. She was discharged and returned to the facility at 5:00 p.m. An NP note, dated 8/7/22 at 10:48 p.m., indicated the resident was seen following her hospital stay. She continued with behavioral disturbance and was followed by psychiatric services. At the time of the visit, the resident was fixated and unwilling to discuss medical issues other than her current pain medications. The plan was to change her pain medications and recommended she agree to go to pain management. The resident would continue to receive psychiatric services. An NP note, dated 8/8/22 at 2:13 p.m., indicated the resident was seen for multiple complaints and pain management. She complained about her pain medications, was wearing an ill fitting glove to protect her skin from getting rubbed raw while propelling herself in her wheelchair, she couldn't take her prescribed medication for diarrhea and wanted something else. On 8/15/22 at 3:06 P.M., the resident's preadmission hospital records were reviewed. The records indicated the resident had been seen at the hospital for complaints of chest pain unrelieved with the use of nitroglycerin. She was evaluated and found to have some indications of a light heart attack. While hospitalized, she was observed for symptoms of her psychosomatic (Somatoform) disorder. She had been witnessed to			

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	experience an episode of tremor like irritability but it was uncertain whether the incident was psychosomatic related to the resident being made aware she was going to be discharged. Her discharge diagnoses included Psychosomatic Disorder, asymptomatic at the time of discharge. It was recommended she would benefit from a psychological evaluation. On 8/16/22 at 11:52 A.M., the Administrator provided copies of psychiatric services progress notes. The Administrator indicated the resident had not been seen by psychiatric services until 7/13/22. The resident had an order for these services on 5/2/22 and the NP progress notes, beginning on 5/17/22, indicated the resident was receiving psychiatric services. Psychiatric Services Progress notes indicated the following: -7/13/22, the resident was seen by the counselor to establish care. The note indicated the resident had been having many difficulties recently, was very demanding, verbally aggressive and demeaning to staff when they didn't do what she wanted. The residents history, symptoms, and current presentation appeared consistent with depression and anxiety. The residents diagnoses list hadn't indicated the resident had somatoform disorder. There was no behavior plan put into place or recommendations provided. The resident was seen by the counselor on 7/20/22 and 8/3/22. There were no behavior plans documented or recommendations made. -7/18/22, the resident was seen by the psychiatric NP. The NP indicated the resident was referred for management of depression and anxiety. The resident indicated she wasn't sleeping well and			

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	155446	A. BUILDING 00 B. WING	08/16/2022

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	was agreeable to try a sleeping aid. The note hadn't indicated the resident had somatoform disorder. The resident was visited on 8/8/22. She was found to be very agitated and resistant to being calmed. She told the NP that she wasn't crazy and didn't need any of her medications. On 8/16/22 at 3:15 P.M., the DON was interviewed. She indicated she wasn't sure why the resident had not been seen by psychiatric services prior to 7/13/22. The facility usually held behavior meetings and monitored behaviors monthly however the facility was currently without a Social Services Designee and the corporate Social Services Director was providing services but was not present daily. On 8/16/22 at 4:00 P.M., the Administrator and DON were interviewed. Both indicated they had not been aware the resident had been diagnosed with somatoform disorder or how that would affect the resident's care. There was not a person centered care plan developed to assist the resident with her fixation on medical issues, extreme pain she felt, the possible relation to her diagnosis, behaviors she had when she believed her concerns weren't taken seriously and acted upon as quickly as she believed they should be. The DON indicated the resident's diagnoses explained many of the residents behaviors. She indicated the resident was complaining of uncontrollable shaking and not feeling well despite her vital signs being normal and no obvious abnormalities noted on her nursing assessment. A current policy titled "Mood and Behavior Management" and provided by the DON on 8/16/22 at 4:12 P.M., stated the following:"It is the policy of the facility to provide interventions for			

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	all residents with behavioral and/or mood indicators that may be problematic or distressing. Residents are provided a supportive environment that is aimed at prevention, relief and/or accommodation of their behavior and/or mood in addition to interventions that are specific to the resident's individualized needs...." Somatic symptom disorder and interventions was retrieved from Lippincott Advisor App., revised on 4/1/22, on 8/16/22 at 4:30 P.M. and indicated the following:"Overview: Somatic symptom disorder is a mental disorder in which multiple recurring physical symptoms, including pain, occur that are real to the patient but cannot be explained by any diagnosed medical condition or the direct effect of a substance...Patients express excessive worry about symptoms and repeatedly seek medical reassurance...Stress often worsens symptoms...Complications: Addiction to prescription pain medications, depression, anxiety...Nursing interventions: Convey sincere interest in the patient rather than in the reported symptoms; Reinforce the patients sense of self worth; Acknowledge the patients concerns then move the discussion away from symptoms; Identify and discuss the patients emotions; Assess the patients pain level; Assess social patterns; Teach the patient relaxation techniques that assist with coping with symptoms of the illness...Monitor response to medications, use of pain medications and their effectiveness, signs of suicidal ideation, and safety...Consider depression or hostility monitoring and precautions...." This Federal tag relates to Complaint IN00387518. 3.1-43(a)(1)			