PRINTED: 11/13/2023

					I IXII	LED
DEPARTMENT OF HEALTH AND HUM	FOR	RM APPROVED				
CENTERS FOR MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
	155446	B. WING		NG 10/27/		2023
			200 FF			
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
			5700 W	ILKIE DR		
MAJESTIC CARE OF JEFFERSON POINTE			FORT V	VAYNE, IN 46804		
OVA ID CID OLD OVA	OT A TEMENT OF DEFICIENCIE		ID			(V5)

MAJESTIC CARE OF JEFFERSON POINTE			FORT WAYNE, IN 46804			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
0000						
Bldg. 00						
3	This visit was for the Investigation of Complaints	F 0000	The creation and submission of			
	IN00419445 and IN00419911		this plan of correction does not constitute an admission by this			
	Complaint IN00419445-No Federal/State		provider of any conclusion set forth			
	deficiencies related to the allegations are cited.		in the statement of deficiencies, or			
	Complaint IN00419911-Federal/State deficiencies		of any violation of regulation. This provider respectfully requests that			
	1 -		the 2567 Plan of Correction be			
	related to the allegations are cited at F684, F699, F742, and F745.		considered the Letter of Credible			
	1772, and 1773.		Allegation and respectfully			
	Survey date: October 27, 2023		requests a Post			
			Survey Desk Review			
	Facility number: 000476					
	Provider number: 155446					
	AIM number: 100290870					
	Census Bed Type:					
	SNF/NF: 90					
	Total: 90					
	Census Payor Type:					
	Medicare: 3					
	Medicaid: 69					
	Other: 18					
	Total: 90					
	These deficiencies reflect State Findings cited in					
	accordance with 410 IAC 16.2-3.1.					
F 0684	483.25					
SS=D	Quality of Care					
Bldg. 00	§ 483.25 Quality of care					
	Quality of care is a fundamental principle that					
	applies to all treatment and care provided to					
	1					
	facility residents. Based on the					
	comprehensive assessment of a resident, the					
	facility must ensure that residents receive					

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

Shawn Blackburn

TITLE

RN, Regional Nurse Consultant

(X6) DATE 11/11/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W8DL11 Facility ID: 000476 If continuation sheet Page 1 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155446	B. W	ING		10/27/	2023
NAME OF P	DROWNED OF CURPUSE		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		5700 WILKIE DR				
MAJEST	IC CARE OF JEFFE	ERSON POINTE		FORT \	WAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		L LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e in accordance with					
		lards of practice, the					
	and the residents'	erson-centered care plan,					
		choices.	F 0	691	1. What corrective		11/14/2023
			FU	004	action(s) will be accomplished	nd	11/14/2023
	Based on interview	and record review the facility			for those residents found to	s u	
		ely physician notification for 1			have been affected by the		
	of 3 residents reviewed. (Resident B)				deficient practice;		
		(MD/NP was notified on 10-17	of	
	Findings include:				occurrence for Res B. No adv		
1 monigo monavo				effects noted to resident B.			
An event reported by the facility to the Indiana				2. How other residents	5		
Department of Health indicated there was a				having the potential to be			
concern for a resident who had inflicted				affected by the same deficien	nt		
	self-injuries with a	razor.			practice will be identified and	d	
					what corrective actions(s) w	ill	
	In an interview on 1	0/27/23 at 10:25 AM the			be taken;		
		ated Resident B had			All residents who ha	ve	
	1	ft arm with a razor. The			attempts of self-harm have the	e	
		ated they were unaware of			potential to be affected by the		
	how the resident ha	d obtained a razor.			alleged deficient practice. A		
					whole house audit of all reside		
		was reviewed on 10/27/23 at			will be completed to assess for	r	
	_	ses included schizoaffective			self-harm and ensure MD/NP		
		sorder, alcohol dependence,			notification is completed if not	ed	
		e, major depressive disorder, disorder, non-Alzheimer's			by 11-14-23.		
	1 -	other unspecified behavioral			3. What measures will		
	disturbances and im	-			be put into place and what systemic changes will be ma	do	
	distuivances and III.	ipuise district.			to ensure that the deficient	iu C	
	Resident B's curren	t comprehensive Minimum			practice does not recur;		
		ted 8/8/23 indicated their Basic			Nursing staff educate	ed.	
	` ′	al Status (BIMS) score was 9			by DNS to ensure MD/NP	.	
		e impairment). The MDS			notification is completed at tim	ne of	
	l ,	nt felt hopeless or depressed,			occurrence by 11-14-23. An a		
		g, felt tired with minimal			will be completed each busine		
		, moved slowly and spoke			day to assess for any need of		
	slowly nearly every				MD/NP notification X6 months		
		-			4. How the corrective		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155446	B. W	ING		10/27/2	2023
		<u> </u>	1	CTREET	DDDEGG CHTV CT TT TD CCT	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
NAA 1507	10 04DE 05 1555	EDOON DOINTE			ILKIE DR		
MAJEST	IC CARE OF JEFFI	EKSON POINTE		FORTV	VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A physician order of	dated 8/1/23 indicated Resident			actions(s) will be monitored	to	
	B could be treated l	by a Psychiatrist and a			ensure the deficient practice		
	Psychologist.				will not recur, i.e., what qual	ity	
					assurance program will be p	ut	
	Resident B's Level	2 Preadmission Screening and			into place;		
	Resident Review (F	PASRR) dated 12/10/21			Results of audits will	be	
	indicated the reside	ent had an extensive history of			discussed at monthly Quality		
	inpatient psychiatri	c admissions due to			Assurance Meetings. If 100%	.	
	elopement, refusing	g medications and physical			threshold is not met, then an		
		sident was no longer a			action plan will be developed.	The	
		ed living arrangements due to			QA committee will adjust audi	ts	
frequent alcohol intoxication and disruptive				based on findings.			
behaviors. Resident B required specialized mental							
	health services.						
	and revised on 8/16 psychosocial, ment	al and behavioral needs being					
		indicated the resident had a					
	1 ~	ors. Interventions included					
	_	esident to answer questions and					
		Other interventions included					
	behaviors and follo	W Level 2 PASSR Resident B's behaviors were					
	recommendations v	dent B's Level 2 PASSR					
	1000111111011101118 V	were not specified.					
	Resident B's curren	at care plan focus of					
		order, substance use disorder,					
		alcohol dependence dated					
		date of 11/1/23 indicated the					
		of decreased psychosocial					
		itions included mental health					
	services.						
	A progress note dat	ted 10/17/23 indicated					
		en evaluated due to the facility					
	nursing staff's repor	rt of self-inflicted wounds on					
	the resident's left ar	rm. The writer indicated the					
	nursing staff had re	portedly observed Resident	1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00		SURVEY LETED 7/2023	
	PROVIDER OR SUPPLIER		5700 W	ADDRESS, CITY, STATE, ZIP COE /ILKIE DR // WAYNE, IN 46804)	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION
TAG	B's self inflicted cut 10/14/23. Resident their injuries were f indicated the nursin resident had been ea foreign objects wrap body cavities. The v psychiatric services of the physician hav B's self injurous bel A Psychiatry Initial 11:09 AM indicated evaluated for an init management of psy psychiatric condition Resident B had beet long-term care facil significant history of abuse which could the living facilities. Residented poor insig at previous facilities hehaviors including nursing staff, disobe elopement at previous facility staff had rep Resident B's room. reported Resident B items and had place their body cavities. scratches on their an fall. The writer had who had worked the observed Resident B In an interview on I Administrator indice	Consult dated 10/18/23 at I Resident B had been tial baseline visit for chotropic medications and ms. The consult indicated in admitted to a different ity on 12/3/21 due to a of alcohol and substance mot be managed in assisted sident B had no permanent foort system. Resident B had ght and poor safety awareness is. Resident B had displayed a rapid mood change, striking eying facility rules and mus facilities. The current foorted removing 3 razors from The current facility staff had a had been eating non-edible dicigarettes and soap inside Resident B indicated m was due to having had a then confirmed the facility staff the previous weekend had B's cuts. 10/27/23 at 11:25 AM the ated Resident B's self-inflicted	TAG	DEFICIENCY		DATE
	injury had occurred	OH 10/1//43. THE	1	I		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/27/2023			
	PROVIDER OR SUPPLIER		5700 W	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	Administrator indic documentation entri happened on 10/14/ indicated they were self-injury on 10/17 RN 4 indicated they administrator was a 10/17/23. The Administrator was a 10/17/23. The Administrator indic without a full time of the self-indicated and a month ago. In an interview on 1 Nurse (RN) 4 indicated Res likes to be alone. RI believe self-isolatin self-harm. RN 4 indicated with the covarious mental heal support, addiction a benefit from receiving indicated the facility Resident B to a more choices were limited. In an interview on 1 indicated they had reached they had resident should have services since the time. The Facility Assess facility would manage of the self-indicated they had resident should have services since the time.	ated they were unaware of 3 ies that reflected the event 23. The Administrator made aware of Resident B's 1/23. If you were present when the made aware of the event of inistrator and RN 4 indicated acility management should are immediately. The ated the facility had been Social Service Director (SSD) 10/27/23 at 12:43 PM Registered ated Resident B did not voice a elf-harm or suicidal ideation. ident B is self-isolating and N 4 indicated they did not go behavior was a predictor of licated a resident who combination of self-isolation, the diagnoses, no family and aggressive behavior would ang psychiatric services. RN 4 you had been trying to transfer the appropriate environment, but did due to the resident's age. 10/27/23 at 12:53 PM the SSD and been employed at the ent B was admitted. The SSD atts should be assessed for sion. The SSD indicated the elbeen receiving mental health			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/27/2023			
	ROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0699 SS=D Bldg. 00	disorder, (PTSD) ar The Facility Assess would identify haza This citation is relat 3.1-37 483.25(m) Trauma Informed §483.25(m) Traum The facility must e are trauma survive competent, trauma accordance with p practice and accor experiences and p eliminate or mitiga re-traumatization of Based on interview failed to ensure the trauma informed ca reviewed. (Resident Findings include: An event reported b Department of Heal concern for a reside self-injuries with a re Resident B's record 10:50 AM. Diagnos disorder, bipolar dis nicotine dependence generalized anxiety	do other psychiatric diagnoses. ment indicated the facility rds and risks for residents. ed to complaint IN00419911. Care na-informed care nsure that residents who ors receive culturally a-informed care in rofessional standards of unting for residents' oreferences in order to te triggers that may cause of the resident. and record review the facility recognition provision of re for 1 of # 3 residents B) y the facility to the Indiana th indicated there was a nt who had inflicted razor. was reviewed on 10/27/23 at es included schizoaffective forder, alcohol dependence, e, major depressive disorder, disorder, non-Alzheimer's	F 0699	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B assessed for traum 2 How other residents having the potentiat to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents who have a histor trauma have the potential to be affected by the alleged deficient practice. All residents will be assessed for trauma by 11-14. 3 What measures we be put into place and what	11/14/2023 na. al e ry of e nt -23. vill
	disturbances and im	, other unspecified behavioral pulse disorder.		systemic changes will be ma to ensure that the deficient	iue

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

PRINTED: 11/13/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		A. BUILDING B. WING	00 00	COMPLETED 10/27/2023	
	PROVIDER OR SUPPLIER		5700 W	ADDRESS, CITY, STATE, ZIP COD /ILKIE DR WAYNE, IN 46804	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Data Set (MDS) dat Interview for Menta (moderate cognitive indicated the resider had trouble sleeping energy, felt restless, slowly nearly every Resident B's Level 2 Resident Review (P indicated the resider inpatient psychiatric elopement, refusing aggression. The resi candidate for assiste frequent alcohol into behaviors. A progress note data Resident B had beer Practitioner due to t report of self-inflict left arm. The Writer had reportedly obse over the weekend or indicated their injur writer indicated the resident had been ea foreign objects wrap body cavities. A Psychiatry Initial 11:09 AM indicated evaluated for an init management of psyc psychiatric conditio Resident B had beer	2 Preadmission Screening and ASRR) dated 12/10/21 at had an extensive history of admissions due to medications and physical dent was no longer a add living arrangements due to exication and disruptive and 10/17/23 indicated an evaluated by the Nurse he facility nursing staff's ed wounds on the resident's indicated the nursing staff rived Resident B's self- injuries an 10/14/23. Resident B had lies were from scratching. The nursing staff later reported the atting gloves and placing oped in gloves inside their		practice does not recur; Social Service Director in-service by corporate Social Service regarding trauma informed car 11-14-23. Social Service Director will audit each new admission moving forward to ensure traux is assessed at admission X6 months. 4	re by ctor ma /e to ty ut ssed s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/27/2023			
	ROVIDER OR SUPPLIER		5700 W	ADDRESS, CITY, STATE, ZIP COD /ILKIE DR // WAYNE, IN 46804	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ce abuse which could not be	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION
	alcohol and substan managed in assisted had no permanent a system. Resident B poor safety awarene Resident B had disprapid mood change, disobeying facility previous facilities. reported removing froom. The current from the current from the current from the sident B had been had placed cigarette cavities. Resident B due to having had a had observed Resident B difficult early childled Resident B did not be parents' names with indicated Resident B did not be parents' names with indicated Resident B to discuss past traur continued to impact Resident B's current newly admitted to the psychosocial, mentaged and the problem of behaviors and to fol recommendations. It	ce abuse which could not be living facilities. Resident B ddress and no support had exhibited poor insight and ess at previous facilities. Dlayed behaviors including striking nursing staff, rules and elopement at The current facility staff had B razors from Resident B's facility staff had reported in eating non-edible items and est and soap inside their body of indicated they had scratches fall. The writer indicated staff ent B cutting themselves with story Initial Review dated esident B had memories of a mood. The review indicated have any family support and were unknown. The review B indicated they did not want matic events that had etheir life. It care plan focus of being the facility with a goal of all and behavioral needs being indicated the resident had a res. Interventions included seident to answer questions and Other interventions included low Level 2 PASSR Resident B's behaviors were ent B's Level 2 PASSR			
		0/27/23 at 12:43 PM Registered			

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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	UILDING	00	COMPLETED	
		155446	B. W	'ING	_	10/27/2023	
		·		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ILKIE DR		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE			VAYNE, IN 46804		
(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	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	ated Resident B did not voice a					
	1	RN 4 indicated Resident B was					
	_	ked to be alone. RN 4 indicated					
	1 -	self-isolating behavior meant					
		istory of trauma. RN 4					
		nation of self-isolation,					
		th diagnoses, no family					
		and aggressive behavior could attic history. RN 4 indicated the					
	_	ring to transfer Resident B to a					
		nvironment, but choices were					
	limited due to the re						
	ininited due to the re	esident's age.					
	In an interview on 10/27/23 at 12:53 PM the Social						
		SD) indicated they had not					
		ne facility when Resident B					
		SSD indicated all residents					
		for trauma upon admission.					
		•					
	A current policy dat	ted 3/2019 provided by the					
		facility would implement					
	universal trauma scr	reenings for all residents.					
	The Facility Assess	ment dated 5/23 indicated the					
	1	age the care of individuals with	1				
	_	post-traumatic stress					
		nd other psychiatric diagnoses.					
	1	ment indicated the facility					
	would identify haza	ards and risks for residents.					
	This citation is relat	ted to complaint IN00419911.					
F 0742	483.40(b)(1)						
SS=D	1 ' ' ' '	Mental/Psychoscial					
Bldg. 00	Concerns	•					
-	§483.40(b) Based	on the comprehensive					
	- ' '	esident, the facility must					
	ensure that-	•					
	§483.40(b)(1)						
		splays or is diagnosed with					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE (ULTIPLE CO	ONSTRUCTION (X3) DATE SURVI		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLE		ETED	
		155446	B. W	NG		10/27/	/2023
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
NAA IECT		EDCON DOINTE			/ILKIE DR		
MAJEST	IC CARE OF JEFFI	ERSON POINTE		FORT	WAYNE, IN 46804		
(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 IN CROSS-REFERENCED TO THE APPROP		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	mental disorder o	r psychosocial adjustment					
difficulty, or who has a history of trauma							
	and/or post-traum	atic stress disorder,					
	receives appropria	ate treatment and services					
	to correct the ass	essed problem or to attain					
	the highest practic	cable mental and					
	psychosocial well-	-being;					
			F 0'	742	1 What corrective		11/14/2023
	Based on interview and record review the facility				action(s) will be accomplished	ed	
	failed to assess and	track behavior for 1 of 3			for those residents found to		
	residents reviewed.	(Resident B)			have been affected by the		
					deficient practice;		
Findings include:				The facility is unable to correct	t the		
					alleged deficient practice for		
	An event reported by the facility to the Indiana				Resident B. Resident B's		
	Department of Hea	lth indicated there was a			behaviors will be tracked movi	ing	
	concern for a reside	ent who had inflicted			forward.		
	self-injuries with a	razor.			2 How other		
					residents having the potentia	al	
		10/27/23 at 10:25 AM the			to be affected by the same		
		eated Resident B had			deficient practice will be		
	-	ft arm with a razor. The			identified and what correctiv	е	
		cated they were unaware of			actions(s) will be taken;		
	how the resident ha	d obtained a razor.			All residents who have behave		
					have the potential to be affected		
		was reviewed on 10/27/23 at			by the alleged deficient practic		
		ses included schizoaffective			An audit of all residents will be	;	
	_	sorder, alcohol dependence,			completed by Social Service		
	_	e, major depressive disorder,			Director by 11-14-23 to initiate	•	
		disorder, non-Alzheimer's			behavior tracking.		
	· ·	, other unspecified behavioral			3 What measures w	/ill	
	disturbances and in	npulse disorder.			be put into place and what		
	D 11 . D				systemic changes will be ma	de	
		t comprehensive Minimum			to ensure that the deficient		
		ted 8/8/23 indicated their Basic			practice does not recur;		
		al Status (BIMS) score was 9			Social Service Director in-serv		
		e impairment). The MDS			by corporate SSD on behavior	-	
		ent felt hopeless or depressed,			tracking by 11-14-23. All		
		g, felt tired with minimal			residents with behaviors will be	е	
	energy, felt restless	, moved slowly and spoke			tracked each business day to		

CELLIERO I OI	THE CONTENTS OF THE PARTY	THE SERVICES			32		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155446	B. WING	<u> </u>	10/27/2023		
NAME OF F	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP COD			
				/ILKIE DR			
MAJEST	IC CARE OF JEFFI	ERSON POINTE	FORT	WAYNE, IN 46804			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	slowly nearly every			ensure appropriate follow up i			
				completed X6 months.			
	A physician order d	lated 8/1/23 indicated Resident		4 How the corrective	, _A		
		by a Psychiatrist and a		actions(s) will be monitored	-		
	Psychologist.	by a 1 sychiatrist and a					
	r sychologist.			ensure the deficient practice			
	D: 1 1	2 D di S		will not recur, i.e., what qual	-		
		2 Preadmission Screening and		assurance program will be p	out		
	· ·	PASRR) dated 12/10/21		into place;	.		
		ent had an extensive history of		Results of audits will be discu	ssea		
inpatient psychiatric admissions due to			at monthly Quality Assurance				
elopement, refusing medications and physical			Meetings. If 100% threshold i				
	aggression. The resident was no longer a			not met, then an action plan w			
	candidate for assisted living arrangements due to			be developed. The QA comm	nittee		
	_	toxication and disruptive		will adjust audits based on			
	behaviors. Resident	t B required specialized mental		findings.			
	health services.						
	Recident R's curren	at care plan focus with a goal of					
		al and behavioral needs being					
		indicated the resident had a					
	1 ~	ors. Interventions included					
	_	esident to answer questions and					
	I -	Other interventions included					
		llow Level 2 PASSR					
		Resident B's behaviors were					
	_	dent B's Level 2 PASSR					
		were not specified. There was					
	no triggering events	s identified.					
	A progress note dat	ted 10/1/23 at 11:54 PM					
		B had been pacing and					
	peeking into other i						
	pecking into other i	restuent 8 100ms.					
	A progress note dat	ted 10/19/23 at 11:08 AM					
	indicated Resident	B had been wandering,					
	rummaging through	n cabinets and nurse station					
		had been found in rooms.					
	,						
	A progress note dat	ted 10/19/23 at 1:41 PM					

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indicated Resident B had been wandering, talking

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING D. WING		00	COMPL	ETED			
		155446	B. W	NG			/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ILKIE DR		
MAJEST	IC CARE OF JEFFE	FRSON POINTE			VAYNE, IN 46804		
			1				ı
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PR FETY (EACH CORRECTIVE ACTION SHOULD B			(X5)	
PREFIX	,			PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	to a wall hanging ar	nd laughing.					
	A museussamete det	ad 10/17/22 indicated					
		ed 10/17/23 indicated n evaluated due to the facility					
		rt of self-inflicted wounds on					
	-	m. The Writer indicated the					
		portedly observed Resident					
	,	e weekend on 10/14/23.					
		icated their injuries were from					
		ter indicated the nursing staff					
	_	esident had been eating gloves					
	-	objects wrapped in gloves					
		vities. There was no indication					
	-	g of the self injurous behavior					
	or of the PICA.	3					
	A Psychiatry Initial	Consult dated 10/18/23 at					
	11:09 AM indicated	d Resident B had been					
	evaluated for an ini	tial baseline visit for					
	management of psy	chotropic medications and					
	psychiatric conditio	ons. The consult indicated					
	Resident B had been	n admitted to a long-term care					
	facility on 12/3/21 of	due to a significant history of					
		ice abuse which could not be					
	_	l living facilities. Resident B					
	•	ddress and no support					
		had exhibited poor insight and					
		ess at previous facilities.					
	-	played behaviors including					
		, striking nursing staff,					
		rules and elopement at					
	_	The current facility staff had					
	-	3 razors from Resident B's					
		acility staff had reported					
		n eating non-edible items and				ļ	
		es and soap inside their body				ļ	
		B indicated they had scratches					
	_	fall. The writer had then					
		ity staff had observed Resident					
	B cutting themselve	es with a razor.	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/27/2023					
		100770	D. WII	_		10/21/	2020
NAME OF I	PROVIDER OR SUPPLIE	R			.DDRESS, CITY, STATE, ZIP COD ILKIE DR		
MAJEST	IC CARE OF JEFF	ERSON POINTE			VAYNE, IN 46804		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `		I F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	A Social Service H 10/9/23 indicated H difficult early child Resident B did not her parents' names indicated Resident to discuss past trau continued to impace Resident B's behave through 10/26/23 in displayed wanderin behavior monitor of behaviors of rumm objects, talking to to or taking items that was no indication of behaviors to identify In an interview on Administrator indic documentation ente happened on 10/14 indicated they were self-injury on 10/17 present when the A of the event of 10/18 RN 4 indicated the management shoul immediately. The A facility had been w Director (SSD) unter In an interview on Nurse (RN) 4 indicated history of trauma, s	R LSC IDENTIFYING INFORMATION Resident B had memories of a dhood. The review indicated have any family support and were unknown. The review B indicated they did not want imatic events that had be their life. From monitor dated 9/28/23 indicated the resident had ing and grabbing behaviors. The did not include the resident's haging, talking to inanimate themselves, injuring themselves to do not belong to them. There of tracking prior events to fry triggers. 10/27/23 at 11:25 AM the cated Resident B's self-inflicted do n 10/17/23. The cated they were unaware of 3 ries that reflected the event which aware of Resident B's 7/23. RN 4 indicated they were administrator was made aware and aware and facility do have been made aware Administrator indicated the without a full time Social Service with a month ago. 10/27/23 at 12:43 PM Registered cated Resident B did not voice a self-harm or suicidal ideation.		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
		sident B was self-isolating and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446						COMPLETED	
		155446	B. WI	NG		10/27/	2023
NAME OF P	ROVIDER OR SUPPLIER	- !			ADDRESS, CITY, STATE, ZIP COD		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE			ILKIE DR VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORR			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		N 4 indicated they did not					
		g behavior was a predictor of					
		licated a resident who combination of self-isolation,					
	*	th diagnoses, no family					
		and aggressive behavior would					
		ing psychiatric services. RN 4					
		y had been trying to transfer					
		re appropriate environment, but					
	choices were limite	d due to the resident's age.					
		10/27/23 at 12:53 PM the SSD					
		not been employed at the					
	<u> </u>	ent B was admitted. The SSD					
		nts should be assessed for supon admission. The SSD					
		nt should have been receiving					
		ces since the time of admission.					
	The Facility Assess	ment dated 5/23 indicated the					
	-	age the care of individuals with					
		post-traumatic stress					
		nd other psychiatric diagnoses.					
		ment indicated the facility					
	-	ards and risks for residents.					
	-	ment indicated the facility causes of psychiatric					
		viors and implement					
	personalized interve						
	psychosocial wellne						
	This citation is relat	ted to complaint IN00419911.					
	3.1-43(a)(1)						
F 0745 SS=D		cally Related Social Service					
Bldg. 00	- ' '	cility must provide					
	-	social services to attain or					
	mamam me nigne	est practicable physical,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446				UILDING	00	COMPLETED
		155446	B. W	ING		10/27/2023
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF P	PROVIDER OR SUPPLIEF	(5700 W	/ILKIE DR	
MAJESTI	IC CARE OF JEFFE	ERSON POINTE		FORT \	WAYNE, IN 46804	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		osocial well-being of each				
	resident.		F 0/	7.4.5		11/14/2022
	D 1 '4 '	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 0'	745	1 What corrective	11/14/2023
		and record review the facility			action(s) will be accomplished	
		provision medically related			for those residents found to	
Social Services for		1 of 3 residents reviewed.			have been affected by the	
	(Resident B)				deficient practice;	
Findings include:					Resident B was referred to ps	•
	Findings include:				services and seen on 10-18-2	3.
	A4 4 11	and Calling and T. 1			2 How other	-1
	An event reported by the facility to the Indiana Department of Health indicated there was a				residents having the potenti	al
					to be affected by the same	
concern for a resident who had inflicted				deficient practice will be		
	self-injuries with a	razor.			identified and what corrective	re
	T., !	10/27/22 -4 10:25 AM 41			actions(s) will be taken;	.t.
		10/27/23 at 10:25 AM the			All residents who require psyc	
		eated Resident B had			services have the potential to	
	-	ft arm with a razor. The			affected by the alleged deficie	ent
		eated they were unaware of			practice. An audit will be	
	how the resident ha	d obtained a razor.			completed on all residents to	
	Dogidant Dia magand	was reviewed on 10/27/23 at			ensure they have psych service	
		ses included schizoaffective			available if needed by 11-14-2	
	_	sorder, alcohol dependence,			3 What measures v	VIII
	_	e, major depressive disorder,			be put into place and what	ndo
	-	disorder, non-Alzheimer's			systemic changes will be ma	iue
	-	, other unspecified behavioral			practice does not recur;	
	disturbances and in				Social Service Director inserv	iced
	distuibances and in	ipuise disorder.			by corporate Social Services	
	Resident R's curren	t comprehensive Minimum			ensure all residents are follow	
		ted 8/8/23 indicated their Basic			by pscyh services if needed.	lou
	` ′	al Status (BIMS) score was 9			Social Service Director will au	dit
		e impairment). The MDS			all new admissions to ensure	MIL
		nt felt hopeless or depressed,			psych referral is completed if	
		g, felt tired with minimal			needed X6 months.	
		, moved slowly and spoke			4 How the corrective	/A
	slowly nearly every				actions(s) will be monitored	-
	Slowly healty every	auj.			ensure the deficient practice	
	A nhysician order d	lated 8/1/23 indicated Resident			will not recur, i.e., what qual	
		by a Psychiatrist and a			assurance program will be p	-
	L could be ireated t	o j a i o j ciliani lon alla a	ı		assurance program will be p	, ut

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	
		155446	B. W	ING		10/27	/2023
NAME OF T	ADOLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			5700 W	ILKIE DR		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE		FORT V	VAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Psychologist.				into place;		
	Pacidant R's Laval	2 Preadmission Screening and			Results of audits will be discus at monthly Quality Assurance	ssea	
		_			Meetings. If 100% threshold is	•	
Resident Review (PASRR) dated 12/10/21 indicated the resident had an extensive history of inpatient psychiatric admissions due to elopement, refusing medications and physical aggression. The resident was no longer a candidate for assisted living arrangements due to					not met, then an action plan w		
					be developed. The QA comm		
					will adjust audits based on		
					findings.		
					· ·		
	_	oxication and disruptive					
		B required specialized mental					
	health services.						
		t care plan focus of being					
	•	he facility dated 8/2/23 and					
		with a goal of psychosocial,					
		ral needs being met dated a problem of					
		tions included allowing time					
		er questions and verbalize					
		rventions included behaviors					
	-	1 2 PASSR recommendations.					
		ors were not specified.					
		2 PASSR recommendations					
	were not specified.						
	Resident B's curren	-					
		order, substance use disorder,					
		lcohol dependence dated					
	_	date of 11/1/23 indicated the					
		of decreased psychosocial					
	services.	tions included mental health					
	SCI VICCS.						
	A progress note dat	ed 10/17/23 indicated					
		n evaluated due to the facility					
		t of self-inflicted wounds on					
	-	m. The writer indicated the					
	nursing staff had re	portedly observed Resident					
		over the weekend on 10/14/23.					
							I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPL	ETED	
		155446	B. W	ING		10/27/	/2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2		1	ILKIE DR		
MAJEST	IC CARE OF JEFFE	EDSON DOINTE			VAYNE, IN 46804		
IVIAJEST	IC CARE OF JEFFE	ERSON POINTE		FORT	VATINE, IN 40804		
(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	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Resident B had indi	icated their injuries were from					
	scratching. The wri	ter indicated the nursing staff					
	later reported the re	sident had been eating gloves					
	and placing foreign	objects wrapped in gloves					
	inside their body ca	vities. The writer referred the					
	resident to psychiat						
	A Psychiatry Initial	Consult dated 10/18/23 at					
		d Resident B had been					
		tial baseline visit for					
		chotropic medications and					
		ons. The consult indicated					
		n admitted to a long-term care					
		due to a significant history of					
		ace abuse which could not be					
		l living facilities. Resident B					
	-	ddress and no support					
	_	had exhibited poor insight and					
	_ ·	ess at previous facilities.					
		blayed behaviors including					
	-	-					
	-	, striking nursing staff,					
		rules and elopement at					
	*	The current facility staff had					
		3 razors from Resident B's					
		acility staff had reported					
		n eating non-edible items and					
		es and soap inside their body					
		3 indicated scratches on their					
		ing had a fall. The writer had					
		facility staff who had worked					
	_	nd had observed Resident B					
	cutting themselves	with a razor.					
		10/27/23 at 11:25 AM the					
	Administrator indic	ated Resident B's self-inflicted					
	injury had occurred	on 10/17/23. The					
	Administrator indic	ated they were unaware of 3					
		ies that reflected the event]
	happened on 10/14/	23. The Administrator					
		made aware of Resident B's					

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	PLAN OF CORRECTION IDENTIFICATION NUMBER 155446 IE OF PROVIDER OR SUPPLIER JESTIC CARE OF JEFFERSON POINTE ID SUMMARY STATEMENT OF DEFICIENCIE FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/27/2023	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION self-injury on 10/17/23. RN 4 indicated they were present when the Administrator was made aware of the event of 10/17/23. The Administrator and RN 4 indicated the physician and facility management should have been made aware immediately. The Administrator indicated the facility had been without a full time Social Service Director (SSD) until a month ago. In an interview on 10/27/23 at 12:43 PM Registered Nurse (RN) 4 indicated Resident B did not voice a history of trauma, self-harm or suicidal ideation. RN 4 indicated Resident B is self-isolating and likes to be alone. RN 4 indicated they did not believe self-isolating behavior was a predictor of self-harm. RN 4 indicated a resident who		5700 W	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	•		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	self-injury on 10/17 present when the A of the event of 10/1 RN 4 indicated the management should immediately. The A facility had been wi Director (SSD) unti In an interview on I Nurse (RN) 4 indicated history of trauma, s RN 4 indicated Res likes to be alone. R believe self-isolatin self-harm. RN 4 ind presented with the o various mental heal support, addiction a benefit from receivi indicated the facility Resident B to a more choices were limite In an interview on I facility when Resid indicated all resider trauma upon admiss resident should hav services since the ti The Facility Assess facility would mana depression, trauma, disorder, (PTSD) at The Facility Assess would identify haza	dministrator was made aware 7/23. The Administrator and physician and facility I have been made aware administrator indicated the thout a full time Social Service I a month ago. 1.0/27/23 at 12:43 PM Registered ated Resident B did not voice a self-harm or suicidal ideation. ident B is self-isolating and N 4 indicated they did not g behavior was a predictor of licated a resident who combination of self-isolation, th diagnoses, no family aggressive behavior would ang psychiatric services. RN 4 y had been trying to transfer appropriate environment, but did due to the resident's age. 1.0/27/23 at 12:53 PM the SSD and been employed at the ent B was admitted. The SSD ints should be assessed for sion. The SSD indicated the eleben receiving mental health				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/13/2023

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	IES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155446	B. WING		10/27/2023		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE			STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804				
(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	3.1-34(a)						

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