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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411119 and IN00411535. Complaint IN00411119 - Federal deficiencies related to the allegations are cited at F557. Complaint IN00411535 - No deficiencies related to the allegations are cited. Survey date: June 26, 2023 Facility number: 000250 Provider number: 155359 AIM number: 100289980 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 1 Medicaid: 54 Other: 9 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 28, 2023	F 0000		
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregg	Fuller	07/07/2023

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

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	personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.			
	Based on interview and record reviews the facility failed to ensure 1 of 3 residents reviewed was treated with dignity and respect. (Resident B) Findings include: On 6/26/2023 at 10:15 A.M., Review of a facility's state reported incident investigation indicated Resident B was left in the shower room for several hours after shift change. A record review for Resident B began on 6/26/2023 at 10:15 AM, indicated diagnoses included but were not limited to Alzheimer's Disease, schizoaffective disorder and bipolar disorder. A review of Resident B's MDS (Minimal Data Set) Assessments dated 3/24/23 indicated a BIMS (Brief Interview for Mental Status) was 13/15, meaning cognitively intact. The annual assessment also indicated the resident required supervision with set up only for walking in room, halls and locomotion on and off the unit. A significant change MDS assessment, dated 5/21/2023 was completed when the resident was admitted to hospice. His BIMS was 07/15, meaning modreate cognitive impairment, although functional status remained as supervision and set up only for walking in room and halls, locomotion on and off the unit and dressing. A review of Resident B's Care Plans indicated the goal for needing assistance with activities of daily living was revised on 6/16/2023, and indicated Resident B would have care needs met daily with	F 0557	F557 D 1. All residents have the right to be treated with dignity and respect. 2. Residents were interviewed to identify, any other concerns related to being treated with dignity and respect as it relates to their shower preferences/routine. No concerns noted. 3. All nursing staff will be educated on proper shift hand offs as well as shower procedures by the Director of Nursing/designee by 7/6/23 4. The Director of Nursing/designee will audit using a QAPI tool titled Shift Hand Off/Shower. This will be completed 5 x a week for 4 weeks, weekly for 4 weeks, and monthly for 3 months to ensure the staff are doing proper hand offs, and following shower procedres. This will be submitted to QAPI monthly for review and any further intervention. 5. 7/7/2023	07/07/2023

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assistance of staff. The Intervention for Bathing/Showering was also revised on 6/19/23 and indicated Resident B required assistance of up one staff member for bathing task, may require CNA to exit and return due to history of behavioral outbursts and paranoia. The plan indicated the resident's needs could fluctuate and to encourage to be as independent as possible. Provide additional assistance as needed.

A review of the facility state reported incident dated 6/8/2023 at 8:01 p.m., indicated Resident B was left in the shower during a staffing change. The report indicated the resident was a very private person, kept the door closed, preferred to not have visitors and often kicked people out of the room. Resident B preferred to do self-care despite needing assistance, and showers without direct over-sight. The investigation found the resident to have been given a shower, staff checked on the resident throughout the process. CNA (Certified Nurse Aide) 5 was scheduled to leave at 8:00 P.M. and handed off Resident B's care to the remaining aides. The investigation indicated CNA 10 thought Resident B's shower was completed. At the 10 PM, shift change, Resident B's room door was closed as normal for the resident. During midnight bed check round, Resident B was not in their room. A search for Resident B began and he was found sitting in the shower room. Resident B was in good spirits, dressed and stated they could not remember how to open the door.

A review of the facility's investigation timeline of the incident dated June 8th indicated Resident B came to the nurses' station, asked for a shower and CNA 5 took the resident for a shower. CNA 9 indicated Resident B came to the nurses' station around 6:00 PM asking for a shower and CNA 5

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	took the resident for a shower sometime after supper. CNA 5 put Resident B in the shower room around 7:00 P.M., went back around 7:45 P.M. and got clean clothes for him to put on. It was time for CNA 5 to leave and Resident B was still in the shower room getting dressed. CNA 5 left at 8:03 PM. There was no indication in the report CNA 5 had reported to any staff Residnet B was in the shower room prior to leaving her shift. CNA 8 indicated she had gone into the shower room around 7:30 P.M., as Resident B had turned on the call light. The Resident requested CNA 8 to give them their clothes. CNA 8 handed the resident their clothes. CNA 5 came to check on the resident and CNA 8 told CNA 5 the resident was putting on dirty clothes. CNA 5 proceeded to get the resident clean clothes. CNA 8 left the shower room. CNA 10 indicated she was not aware Resident B was in the shower room, but when she went to the resident room for a complete bed check, Resident B was not there. CNA 10 indicated she checked the shower room and found the resident sitting there in good spirits. Resident B indicated they had forgotten how to open the door. CNA 11 indicated CNA 10 had found Resident B in the shower room around midnight. The facility investigation records dated June 8, 2023 indicated Care team Member Corrective action Forms were completed for the following staff, CNA 2, CNA 5, CNA 8, CNA 9, and CNA 13. On 6-26-2023 at 11:00 A.M. facility grievance records, provided by the Administrator at 10:10 A.M., indicated a grivance was filed by Resident B's family member on 6/12/2023 and was received on 6/12/2023 by Social Services. The Report of Concern indicated an incident date of 6/8/2023. Resident B reported to their family member, they were left in the shower room for several hours.			

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	The grievance was assigned to Nursing on 6/13/2023 and found Resident B was left to shower by themselves, as per they had always done. The CNA was unaware of Resident B's recent decline since hospice admission. Resident B was now unable to shower themselves. Corrective Actions were taken, staff education and in-service were completed. Staff was educated Resident B was not a total care and required assistance in the shower. Staff were educated on staff hand-off when changing staff providing care. On 6/14/2023 Resident B's family member was notified of the changed to the care plan. The family member was in agreement and signed the form as resolved and satisfied with the resolution. In an interview on 6/26/2023 at 9:40 AM, the Administrator indicated he had reported the incident per policy. He indicated through the investigation it was determined the resident was in the shower room for 4 hours. He indicated the facility did not have cameras on the south hall to determine the exact time in the shower. He indicated the resident was very private, did not like people coming into their room, always keeps the door shut, and rarely came out of their room. Resident B often yelled at persons coming into the room and has been known to throw items at the staff. The resident did not like to take a shower or be touched. He also indicated Resident B's family was very involved and visited often. The family reported the resident said they were in the shower room for 14 hours. The Administrator indicated the resident was known to have delusions, and knew the resident had been seen during the 14 hours reported in the shower. The Administrator indicated Resident B had a decline since being admitted to Hospice. He indicated the facility had a care plan meeting with facility staff,			

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Hospice staff and family. All were in agreement with changes to the care plan to provide total assistance with care and showers.

On 6/26/2023 at 10:50 AM, the DNS (Director of Nursing Services) was in interviewed. She indicated the education in-service was provided by herself, the ADON (Assistant Director of Nursing) and Unit Manager to cover all staff on all shifts. The DON indicated the hand-off report shift to shift was for all residents in the facility. She indicated she was not made aware of the incident until the family reported to the Administrator, and the investigation had already begun. As the investigation was completed, it was determined to report the incident to State on 6/19/2023. She also indicated written corrective action was given to all staff involved.

On 6/24/23 at 2:10 P.M., in an interview, CNA 2 indicated at shift change a room to room hand-off report was to be given about each of the residents, and lay eyes on them. Report how they were doing on their shift, when last changed, if having behaviors. She indicated bed checks should be done every 2 hours. She indicated if a resident would tell her to get out of the room, she would report it to the nurse, and would attempt later with nurse or another staff member to come along.

On 6/24/23 at 2:20 P.M., in an interview, CNA 3 indicated she worked day shift. There were usually 2 CNA's on East and West Halls, and 1 CNA on South Hall, since residents were mostly independent. She indicated a walk through shift to shift report was to be done and need to visualize the residents during the report. She indicated she usually does not work on the South Hall, but indicated Resident B was not on total

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	care and was more accepting of care from staff. On 6/24/2023 at 2:42 P.M., in an interview, CNA 4 indicated the staff had assignment sheets and waould get a report from the prior shift. They would walk room to room, visualize the residents, and check to see if they needed changed prior to leaving. She indicated residents should be checked on at least every 2 hours. She indicated the staff were educated on visually seeing the residents during the report. On 6/24/2023 at 2:50 P.M., in an interview, CNA 5 indicated Resident B was not her assigned resident, The resident had come up to the nurses' station and wanted to get a shower. She indicated she assisted them to get in the shower and told him to pull the light cord. She indicated he didn't want to put on different clothes on, but she asked and he indicated he would put on clean clothes, so she went to get the clean clothes. She indicated she assisted with clean pants, but the resident would not allow her to put on a clean brief, and wanted to dress himself. She indicated she reported to the 4 CNA's who were at the nurses' station, Resident B still needed to get a shirt and jacket on. She indicated her shift ended and she left. She indicated they have been educated to do a shift to shift, room to room report on the residents. They were to inform the oncoming staff how the resident was, if the resident needed showered, or was having behaviors. The staff were instructed to go in the room and check on them. She indicated she waited until the next shift arrived and report was given before leaving, even if it was late and their shift had ended. A current facility policy, titled, Quality of Life-Dignity, revised on February 2020, was			

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	provided by the Administrator on 6/26/2023 at 4:55 P.M., indicated, " ...Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem ...1. Residents are treated with dignity and respect at all times. 2. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values and beliefs ...11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents ...12. Staff are expected to treat cognitively impaired residents with dignity and sensitivity ...." This Federal tag relates to complaint IN00411119. 3.1-9(a)			