STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155359		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 01/09	LETED	
	PROVIDER OR SUPPLIER		7519 W	ADDRESS, CITY, STATE, ZIP COD INCHESTER RD VAYNE, IN 46819		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 0000						
Bldg. 00	Licensure Survey.	55359 89980	F 0000			
F 0757 SS=D Bldg. 00	Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 11, 2023 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary		GNATURE	TITLE		(X6) DATE

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

Gregg Fuller **Executive Director** 01/20/2023

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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155359	B. WING 01/09/2023			/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	₹			/INCHESTER RD		
MAJEST	IC CARE OF FORT	WAYNE			WAYNE, IN 46819		
1717 NOLUT		· · · · · · · · · · · · · · · · · · ·			T		1
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.45(d)(3) Wit	hout adequate monitoring;					
	or						
		hout adequate indications					
	for its use; or						
	\$400 4E/-J\/E\ ! #	he presente of advisors					
	- , , , ,	he presence of adverse					
	consequences which indicate the dose should be reduced or discontinued; or						
	should be reduced	u or discontinued; or					
	8/83 /5(4)(6) /20	combinations of the					
		paragraphs (d)(1) through					
	(5) of this section.						
			F 0'	757	D 757		01/20/2023
	Rased on interview	and record review, the facility	FU	131	0737		01/20/2023
		verse side effects and			1. The identified residents	had	
		dication were monitored for 3			orders written to monitor for	ilau	
		wed. (Resident 55, and			adverse side effects and		
	Resident 12)	wed. (resident 55, and			effectiveness of pain medicati	ion	
	1100100111 12)				2. An audit of all residents		
	Findings included:				orders for scheduled/PRN pai		
					medication and diabetic		
	1. Resident 55's rec	ord was reviewed on 1/5/2023			monitoring was completed by	the	
		oses included multiple			DNS for appropriate monitoring		
	_	betes mellitus without			adverse side effects and	J	
		ess leg syndrome, low back			effectiveness.		
	_	ibromyalgia, chronic pain			The facility protocol has	6	
		raine, unspecified, intractable,			been changed to add these o		
	1 '	osus. A Minimum Data Set			upon onset of the identified cl		
	_	dated 11/23/2022, indicated			of meds. This will be educated		
	. ,	orief interview for mental status			all Nurses and QMA's by the		
	(BIMS) score of 12	(moderate cognitive			by 1/20/2023.		
	impairment).	-			4. The DNS or designee v	vill	
					review all insulin and pain		
	An order, dated 10/	13/2022, indicated Lispro			medication orders 5 times a v	veek	
	Insulin inject, per s	liding scale (dosage based on			for 4 weeks, weekly for 4 wee	ks	
	resident's blood glu	cose reading): if resident's			and monthly for 4 months for		
	blood glucose readi	ing was 150-200=2 units,			compliance with appropriate		
	201-250 = 3 units, 2	251-300 =4 units, 301-350 =5			orders for monitoring and		
	units, 351-400= 6 u	inits, 401-450= 8 units, inject			documenting assessment of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>00</u>			COMPLETED	
		155359	B. WIN	NG		01/09/	2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R			INCHESTER RD			
MAJEST	IC CARE OF FORT	WAYNE			VAYNE, IN 46819			

(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		neath the skin) before meals (hyper/hypo glycemia, and pair	ו		
	7:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (8:00 PM) related to type 2 diabetes mellitus without complications. Call provider if blood glucose reading was over 451.				effectiveness. Results will be			
					submitted to QAPI for review.			
					5. 1/20/23			
	An order dated 12/	3/2022 indicated						
	An order, dated 12/3/2022, indicated Hydromorphone HCl 4 milligrams (mg) tablet (an							
	opioid pain medication), give 1 tablet by mouth							
		eded for pain/discomfort.						
	1 - Cry : Hours as no	tor pain alsoomion.						
	An order, dated 10/13/2022, indicated							
	Hydromorphone HCl 4mg tablet, give 1 tablet by							
	mouth every 4 hours (12:00 AM, 4:00 AM, 8:00							
	1	0 PM, and 8:00 PM) for pain.						
	Resident 55's orders	s did not include an order to						
	_	nd symptoms of hypoglycemia						
		vel) and hyperglycemia (high						
	blood sugar level).							
		d did not include an order to						
		side effects or effectiveness						
	of opioids.							
	,	. 551 1 . ·						
	A review of Reside							
		December 2022 indicated pain						
		n on 12/2/22 at 9:52PM "5",						
		M "1", 12/3/22 at 10:06 PM "6", M "0", 12/5/22 at 3:34 AM "7",						
		I "0", 12/06/22 at 1:10 AM "5",						
		["0", 12/13/22 at 6:21 AM "6",						
		M "2", 12/29/22 at 1:39 AM "8",						
		M "1", and 12/30/22 at 1:56 AM						
		level documentation was						
		aber 2022 vital sign section in						
	Resident 55's record							
	222222222222222222222222222222222222222							
	A review of Reside	nt 55's vital sign						
		January 1-6,2023 indicated pain						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETE			ETED
		155359	B. WI	B. WING 01/09/2023			
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGT		· \^/^ \/			INCHESTER RD		
MAJESTIC CARE OF FORT WAYNE				FORTV	VAYNE, IN 46819		
(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	SHOULD BE COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	level documentation	n on 1/6/2023 at 11:07 AM "8".					
	No other pain level	documentation was found in					
	the January 2023 vi	tal sign section in Resident					
	55's record.						
	A care plan, dated 11/09/2022, indicated Resident						
	55 was at risk for co	omplications and symptoms of					
	hypoglycemia or hy	perglycemia due to a					
		es mellitus. The goal indicated					
	Resident 55 would	be free from symptoms and					
	complications of hy	poglycemia or hyperglycemia.					
	Interventions include	led administer diabetes					
		red by the doctor, observe for					
	side effects and effe	ectiveness, observe for signs					
	or symptoms of hyp	perglycemia such as increased					
	thirst and appetite, t	frequent urination, weight					
	loss, fatigue (tiredne	ess), dry skin, poor wound					
	_	mps, abdominal pain,					
	Kussmaul breathing	g (fast, deep breathing),					
	acetone breath (frui	ty smelling breath), stupor					
	(near unconsciousne	ess) and coma (unconscious),					
	observe for signs ar	nd symptoms of hypoglycemia					
	_	emor (shaking), increased					
		ale skin), nervousness,					
	· ·	peech (unclear speech), lack					
	of coordination and	staggered gait (unsteady					
	walking).						
	_	9/1/2021, indicated Resident					
	_	(constant pain). The goal					
		55 would verbalize adequate					
		nterventions included					
		on as ordered, observe and					
		sual routine, sleep patterns,					
		nal abilities (taking care of own					
	_	dressing), decreased range of					
	· ·	of arms and legs), withdrawal					
		e (not allowing staff to assist),					
		ms of non-verbal pain:					
	changes in breathing (noisy, deep, shallow,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETEI			ETED	
		155359	B. W	B. WING			01/09/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER				INCHESTER RD			
MAJESTIC CARE OF FORT WAYNE				VAYNE, IN 46819				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID BROWINGBIS BLANGE CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE		
	labored, fast/slow),	vocalizations (grunting,						
	moans, yelling out,	silence), mood/behavior						
	changes (more irrita	ble, restless, aggressive,						
	squirmy, constant n	notion), eyes (wide open,						
	narrow slits/shut, gl	azed, tearing, no focus), face						
		d, scared, clenched teeth,						
		se, rigid (stiff), rocking, curled						
		rt to the nurse any change in						
		lance pattern or refusal to						
		ited to signs and symptom or						
	complaint of pain. Resident 55's pain care plan did							
	not include an intervention to monitor for side							
	effects of opioid me	edication.						
	A review of Resider	nt 55's Progress Notes for						
		icated no documentation for						
	monitoring for signs							
		perglycemia. There was no						
		nonitoring for side effects for						
		eded opioid medication.						
		nentation of pain level or						
		administered scheduled						
	opioid medication.	administered semedated						
	A review of Residen	nt 55's Progress Notes for						
	January 2023 indica	ted no documentation for						
	monitoring for signs	s and symptoms of						
	hypoglycemia or hy	perglycemia. There was no						
	documentation for r	nonitoring for side effects for						
	scheduled and as ne	eded opioid medication.						
	There was no docur	nentation of pain level or						
	effectiveness for the	administered scheduled						
	opioid medication.							
	TT N. 1' - ' - 1	''' D LAKEN						
		ministration Record (MAR)						
		inistration Record (TAR)						
		22 indicated Resident 55						
	-	alin on 12/1 at 11:30 AM &						
		30 PM & 8:00 PM, 12/4 at 11:30						
	AM & 4:30 PM, 12	/5 at 4:30 PM & 8:00 PM, 12/6 at						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155359		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/09/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7519 WINCHESTER RD FORT WAYNE, IN 46819					
	SUMMARY (EACH DEFICIEN REGULATORY OR 7:30 AM, 12/7 at 11:2/8 at 11:30 AM, 11:2/10 at 7:30 AM, 11:2/11 at 8PM, 12/12 at 7:30 AM, 11:30 AM, 11:30 AM, 11:30 AM, 11:30 AM, 11:30 AM, 12/17 at 7:30 AM, 12/17 at 7:30 AM, 4:30 PM, 12/17 at 7:30 AM & 4:30 PM, 12/20 at 12/21 at 4:30 PM, 12/21 at 4:30 PM, 12/23 at 8:00 PM, 12/23 at 8:00 PM, 12/25 at 8:00 PM, 12/25 at 8:00 PM, 12/25 at 8:00 PM, 12/25 at 8:00 PM, 12/30 AM, 12	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 1:30 AM, 4:30 PM, & 8:00 PM, 2/9 at 11:30 AM & 4:30 PM, 1:30 AM, 4:30 PM, & 8:00 PM, 2 at 11:30 AM & 8:00 PM, 12/13 AM, 4:30 PM, & 8:00 PM, 12/14 11:30 AM & 8:00 PM, 12/16 at 1:30 AM & 11:30 AM, 12/18 at AM, 12/19 at 11:30 AM, 4:30 PM, t 11:30 AM, 4:30 PM, & 8:00 PM, 12/22 at 11:30 AM & 4:30 PM, 12/24 at 11:30 AM & 4:30 PM, 12/26 at 8:00 PM, 12/27 at 4:30 PM, 12/29 at 11:30 AM & 1:00 PM, and 12/31 at 4:30 PM & 1:00 PM, 4:00 PM, 1/4 at 8 1:00 AM & 8:00 PM, 1:00 PM, 4:00 PM and 8:00 PM on 1:00 PM, 4:00 PM and 8:00 PM on 1:01 PM, 4:00 PM and 8:00 PM on 1:02 PM, 12/14, 12/15, 12/18, 12/22, 12/23, 12/24, 12/25, 12/26, 12/30, and 12/31. Resident 55	7519 W	INCHESTER RD	(X5) COMPLETION DATE			
	at 12:00 AM, 4:00 A 4:00 PM. A dose ware Resident 55 receive tablet on 12/17 at 4: 4:00 PM, and 8:00 A	phone HCl 4mg tablet on 12/16 AM, 8:00 AM, 12:00 PM, and as not given at 8:00 PM. d Hydromorphone HCl 4mg 00 AM, 8:00 AM, 12:00 PM, AM, A dose was not given at as no documentation of pain						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155359		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/09/2023		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	-	
	IC CARE OF FORT			INCHESTER RD VAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION ss of the scheduled pain	TAG	DEFICIENCY		DATE
		•				
	medication on the Mark and TAR through 1/6 12:00 Preceived Hydromor hours at 12:00 AM, 4:00 PM and 8:00 PM and 8:00 PM and 8:00 AM, pain level "8" docur dose, no other docur documentation of expain medication was a medicated Resident of the MAR and TAR indicated Resident of the Mark at 1:39 AM. A pain each administration documented in the pain MAR and TAR through 1/6 12:00 Preceived Hydromor hours as needed for 11:07 AM. A pain administration but reffectiveness was for the MARs and TAR January 2023 indication of the MARS and TAR January 2023 in	AAR and TAR. A dated January 2023 (1/1 PM) indicated Resident 55 phone HCl 4mg tablet every 4 4:00 AM, 8:00 AM, 12:00 PM, PM on 1/1, 1/2, 1/3, 1/4, and 1/5. A received doses at 12:00 AM, A, and 12:00 PM. There was a mented with the 12/6 12:00 PM mentation of pain level or effectiveness for the scheduled as found on the MAR and TAR. A dated December 2022 English at 10:06 PM, 12/5 at 3:34 M, 12/13 at 6:21 AM, and 12/29 level was documented with A dated January 2023 (1/1 PM) indicated Resident 55 phone HCl 4mg tablet every 4 pain/discomfort on 1/6 at evel was documented with the no documentation for				
	indicated side effect psychotropic medic	ts were monitored for ations, antibiotics, insulin, and ocumentation was done in the				

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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 <u>00</u> COMPLETED			ETED	
		155359	B. WI	NG		01/09/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			INCHESTER RD		
MAJEST	IC CARE OF FORT	WAYNE			VAYNE, IN 46819		
		WATER TO THE TOTAL PROPERTY OF THE TOTAL PRO			V/ (114 E, 114 100 10		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	te or progress note every shift.					
		ot have any side effects, a					
	-	ted the resident was okay. RN2					
	_	el was documented before					
	_	needed pain medication, or in a progress note. RN2					
		s were not documented for					
	•	lication. The Assistant					
	•	(ADON) was present during					
	_	RN2 and indicated pain levels					
		ited when as needed pain					
	medication was adn	-					
	modication was adm	initiation cut					
	In an interview on 1	1/6/23 at 9:50 AM, the Director					
		indicated side effects were to					
		iticoagulants, antipsychotics,					
		ibiotics, and any medication					
	_	ged. Residents who received					
	_	nonitored for hypoglycemia.					
		s part of the MAR and					
		The DON indicated they had					
	not been monitoring	g for side effects of opioids.					
	The DON indicated	monitoring side effects of					
	medication was doc	cumented on the MAR, or					
	nurse's notes. Pain l	levels were documented when					
	an as needed pain n	nedication was given and					
		effectiveness, documented on					
		ried over to a progress note.					
		they did not monitor pain					
	-	scheduled pain medication,					
	l '	g on adding this because more					
		iving scheduled pain					
		record review began on					
		AM. Diagnosis for Resident 12					
	_	ain syndrome, rheumatoid					
	· ·	e of muscle (left hand), and					
	abnormal posture.						
	A assembled MDC	gg aggma ant 170g a ann 11-4-4 - 1					
		ssessment was completed on					
	11///2022 for Kesic	lent 12, indicated a BIMS (Brief					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	(X3) DATE	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	A. BUILDING <u>00</u> COMPLETE			ETED
		155359	B. WING 01/09/2023			2023	
			<u> </u>	CTDEET A	DDDESS CITY STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP COD		
MAJECT		· \\\ \\ \\ \\					
MAJEST	IC CARE OF FORT	WATNE		FURIV	VAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Interview for Menta	al Status) score was 10 of 15,					
	which indicated the	resident was mildly					
	cognitively impaire	d.					
		or the medication Norco tablet					
		odone-Acetmaninophen). Give 1					
	-	edtime for pain with a start date					
		was not an order to assess for					
	pain/side effects for	this medication.					
		or the medication Mobic tablet					
). Give 1 tablet by mouth one					
	-	nic pain with a start date of					
		ras not an order to assess for					
	pain/side effects for	r this medication.					
	A raviany of a vitale	summary of the pain level,					
		evel was assessed on 1/2/2023					
		esident 12. There was no other					
	pain level assessed						
	pain level assessed	arter tins date.					
	A care plan indicate	ed Resident 12 is at risk for					
	-	nal gait/mobility, muscle					
	-	are of right and left hand. The					
		ated, administered medication					
		e for side effects of pain					
		ation, new onset or increased					
	-	ess, confusion, hallucinations,					
	-	vomiting, dizziness, and falls.					
	Report occurrences	to the physician.					
	· ·	n administration record) dated					
	· ·	dicated the medication of Noro					
	_	s given at 8:00 PM, for the					
	-	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13,					
		19, 20, 21, 22, ,23, 24, 25, 26, 27,					
		There are no indications the					
		eness of pain level was asked.					
		tions the side effects for this					
	mediations were mo	onitored.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155359	B. WI	NG	_	01/09	/2023
NAME OF T	DOMDED OF CURRY			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C		7519 W	INCHESTER RD		
MAJEST	IC CARE OF FORT	WAYNE		FORT V	VAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
	A MAR dated Dece	ember 2022, indicated the					
		ic tablet 15 mg was given at					
		llowing dates. 1, 2, 3, 4, 5, 6, 7, 8,					
		4, 15, 16, 17, 18, 19, 20, 21, 22, ,23,					
		29, 30, and 31. There are no					
		ssment/effectiveness of pain					
		nere are no indications the side					
	effects for this med	iations were monitored.					
	A MAR dated January 2023, indicated the						
	medication of Noro tablet 5-325 mg was given at						
	8:00 PM, for the following dates: 1, 2, 3, 4, and 5.						
	There are no indica						
	assessment/effectiv	eness of pain level was asked.					
	There are no indica	tions the side effects for this					
	mediations were mo	onitored.					
	A MAR dated Janu	ary 2023, indicated the					
		ic tablet 15 mg was given at					
	8:00 AM, for the fo	ollowing dates: 1,2, 3, 4, and 5.					
	There are no indica	tions the					
	assessment/effectiv	eness of pain level was asked.					
		tions the side effects for this					
	mediations were mo	onitored.					
	A current facility po	olicy, Pain Management, dated					
		ed by the Regional Clinical					
	Consultant on 1/6/2	2022 at 11:22 AM. The policy					
	indicated" Reside	ents are assessed for pain					
		arterly, as needed and during					
		strationResidents receiving					
	_	ation should be assessed each					
	•	nurse during rounds and/or					
	medication passAdditional information						
	-	imited to reasons for					
		effectiveness of pain					
		documented in the electronic					
	medical record"						1
			1				1

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Event ID:

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

PRINTED: 01/24/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 7519 WINCHESTER RD FORT WAYNE, IN 46819					
(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 OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	management, dated Regional Clinical C AM. The policy indidentify residents the and observed them low blood glucose. diagnosis of diabete could lower the blo	olicy, Hypoglycemia 2022, was provide by the consultant on 1/6/2022 at 11:22 dicated" The facility will at are at risk for hypoglycemia for signs and symptoms ofResidents that have a es or on medications that od sugar should have orders ing and treatments of ss otherwise by the						

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