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	01/11/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00425094, Complaint IN00424619, Complaint IN IN00424609, and Complaint IN423698. This visit was inconjunction with the Investigation of Complaint IN00425759. Complaint IN00425094- No deficiencies related to the allegations are cited Complaint IN00424619-Deficiences related to the allegations are cited at F600. Complaint IN00424609-No deficiencies related to the allegations are cited. Complaint IN00423698-No deficiencies related to the allegations are cited. Survey dates: January 7, 8, 9, 10, and 11, 2024 Facility number:000250 Provider number:155359 AIM number:100289980 Census Bed Type: SNF/NF:67 Total: 67 Census Payor Type: Medicaid: 60 Other:7 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Blackburn	RN, Regional Nurse Consultant	01/25/2024

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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	Quality review completed January 12, 2024			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review the facility failed to ensure 1 of 4 residents reviewed were free from abuse. (Resident 22) Findings include: During an interview with Resident 22 on 1/8/24 at 10:16AM she indicated; she did have water thrown on her once, she did not like living at the facility, and she had nothing further to say. During an interview with the Executive Director (ED) and Regional Consulting Nurse (RCN), on 1/08/24 at 1:24PM; they indicated beyond a reasonable doubt CNA 2 (Certified Nurse Assistant) threw a full cup of ice water on Resident 22 while Resident 22 was lying in bed after dinner and before bedtime medication pass on the evening of 12/21/23. The ED explained his investigation process and the difficulty regarding	F 0600	1. Social services assessed for psychosocial distress, none noted. CNA identified was removed from the facility. The CNA was not to return to the facility while investigation was conducted. **2. Interviewable residents were assessed using the abuse questionnaire, no findings. s.3. Staff inserviced on abuse policy and prevention by the Executive Director/Designee immedicately follwong the incident. All staff will be educated upon hire and at a minimum annually on the Abuse Prevention Policy 4. QAPI abuse tool will be completed weekly X 4 weeks,**	01/26/2024

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	staff interviews not validating the abuse and not all cohesive. The ED indicated Resident 22's lack of extreme behavior he would expect if such an incident did occur was initially considered. The lack of eyewitnesses further increased the difficulty in determining if the abuse happened. Resident 22's roommate indicated she did not see the face of the person who came in and had some sort of altercation with Resident 22. The ED was able to determine Resident 22's hair, only a little of a sleeve, and some of the garment's collar was wet in one frame of the footage from a hall camera. The ED was able to see Resident 22 changed her shirt and returned to the nurses' station multiple times. He was further able to determine from cameras CNA 2 had a full pitcher of ice water, went down East Hall where Resident 22 resided and returned with an empty pitcher. CNA 2 was not assigned to East Hall on 12/21/23. The ED indicated in his interview with CNA 2 she denied taking any water down the hall and was unsure what he was talking about. He offered her to come watch the video and she declined. The ED indicated she was unable to account for why she took down a full pitcher of ice water and returned with an empty pitcher. The ED indicated she was unable to account for why she was on East Hall when she was assigned to West. The ED indicated CNA 2 had no prior accusations of abuse or reprimands for performance. Resident 22's chart was reviewed on 1/8/24 at 11:14AM. Resident 22's diagnoses included schizoaffective disorder, major depressive disorder, dementia, insomnia, and anxiety. Resident 22's most recent comprehensive MDS (Minimum Data Set) on 12/14/23 was reviewed. Section C: BIMS (Brief Interview of Mental Status) indicated a score of 13. The score of 13		**bi-monthly X 2 and monthly X 4 months by Executive Director/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**	

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	shows mild cognitive loss. Section D Mood indicated Resident 22 had little or no interest in doing things most days, feeling down, depressed, or hopeless most days, trouble falling or staying asleep most days, feeling tired or no energy several days, poor appetite or overeating most days, and trouble of concentration on things most days. Section E behavior indicated resident had verbal behavior directed toward others and rejection of care for 1 to 3 days out of 14-day period reviewed for assessment. A review of the facility investigation on 1/9/24 at 3:29PM indicated the following: An altercation occurred on 12/20/23, involving Resident 22 and CNA 2. Resident 22 slapped CNA 2. Resident 22 reportedly got upset regarding showering, walked up to CNA 2 at the nurse' station and hit her. A verbal statement was taken from CNA 4 who worked in the evening on 12/21/22 on West Hall and was unaware of any events taking place. A written statement from CNA 3 who worked 12/21/23 in the evening indicated Resident 22 was asked about an incident between her and CNA 2 the day prior. Resident 22 indicated she apologized yet still felt CNA 2 deservedv to be hit. The statement indicated CNA 2 stated "I'm about to go throw some water on her." Then CNA 3 indicated she observed CNA 2 go down East Hall with a full pitcher of ice water. Upon returning, Resident 22 was right behind CNA 2 stating "she threw water on me". 30 to 45 minutes later, Resident 22 came back to nurses' station and indicated CNA 2 threw water on her again. CNA 3 could not confirm if the second incident occurred.			

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	A statement from the DNS (Director of Nursing Services) indicated she asked CNA 2 if she knew anything about water being thrown on Resident 22 and CNA 2 indicated she had no idea what she was talking about. A statement from SSD (Social Services Director) indicated a staff reported to her Resident 22 was very upset due to another staff pouring ice water on her. The statement indicated the SSD spoke with Resident 22 who confirmed the allegation and indicated there was a verbal altercation of statements, "I don't like you" and "I'm going to get even with you". 7 resident abuse questionnaires were completed. Four of the seven indicated the residents also had an issue with CNA 2 but did not report it. CNA 2 was terminated for the abuse. CNA 3 was terminated for failure to report the abuse. During an interview with Resident 22 on 1/10/24 at 1:46PM she indicated she was not more or less depressed than she was prior to the holidays. She denied fearing staff or peers. She denied being bullied or harassed. A policy and procedure were obtained at entrance on 1/7/24 at 9:22AM from ED. The policy "Abuse Prevention Program" original date February 2019 with last revision date March 2021, indicated ...The protection of resident during abuse investigations. The development of investigative protocols governing abuse ... Striving to maintain adequate staffing on all shifts to ensure the needs of each resident were met; and expect all personnel, residents, visitors, to report and signs or suspected abuse to facility management immediately			

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	This citation is realted to Complaint IN00424619. 3.1-27 (a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review the facility failed to ensure residents with trauma had triggers identified for 3 of 3 residents reviewed (Resident 18, Resident 58, & Resident 270). Findings include: 1. Resident 18's record was reviewed on 01/11/24 at 10:31 AM. Diagnoses included Post Traumatic Stress Disorder (PTSD), dementia, and bipolar disorder. A review of Resident 18's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 10 (moderately impaired). The care plan for PTSD did not indicate specific triggers or intervetions to prevent re-traumatization of Resident 18. During an interview an observation on 1-8-24 at 8:10 AM, QMA 6 indicated Resident 18 always had the room dark and cluttered, but there was no direction given the staff on approaches or triggers	F 0699	1.Residents with a diagnosis of PTSD were care planned with specific interventions and triggers. 2.All residents diagnosed or documented to have trauma related clinical outcomes were reviewed by GuideStar services for potential undiagnosed PTSD. Appropriate follow up was completed. 3.Social Service was inserviced by the Executive Director on 1/24/2024 that all residents with the diagnosis of PTSD must have care plans for triggers as well as interventions to those triggers. **4.QAPI abuse tool will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be**	01/26/2024

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	to behavior. 2. Resident 58's record was reviewed on 01/08/24 at 09:38 AM. Diagnoses included PTSD, major depressive disorder, and anxiety disorder. A review of Resident 58's current quarterly MDS indicated their BIMS score was 15 (no cognitive impairment). The care plan for PTSD did not indicate specific triggers to prevent re-traumatization of Resident 58. A review of progress notes dated 11/2/2023 at 1:00 PM indicated Resident 58 continued to have nightmares when he slept, and flashbacks due to trauma from his past. The care plan did not indicate triggers or interventions to be utilized for his nightmares or flashbacks. 3. Resident 270's record was reviewed on 01/11/24 at 12:36 PM. Diagnoses included PTSD, dementia, and generalized anxiety disorder. A review of Resident 270's current quarterly MDS indicated their BIMS score was 99 (resident was unable to complete interview). There were no care plans, approaches, or triggers identifies regarding Residents 270's PTSD. A current policy dated 03/01/2019 provided by the Regional Nurse Consultant indicated the facility should provide care and services identifying triggers, and using multiple person centered approaches to address the needs of trauma survivors. An interview with the Social Service Director on		**presented to the QAPI committee during the monthly meeting="" b="">**	

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	01/11/24 at 1:07 PM indicated trauma or PTSD should be documented in the care plans along with triggers.			
F 0851 SS=C Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);			

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	(ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to ensure accurate reporting to the Payroll-Based Journal (PBJ) system regarding Nursing hours for third quarter 2023. Findings include: A record review on 1/7/2024 at 9:15 AM, of the Certification And Survey Provider Enhanced Reports (CASPER) report: the Payroll-Based Journal (PBJ) data report Quarter 4 2023, July 1-September-30, indicated are of concern that will be triggered (requires follow-up during the survey). The metric: One star staffing rating, triggered. Excessively low weekend staffing,	F 0851	1.During survey the state was shown the accurate hours worked during third quarter. 2.An audit of the month of January was completed to ensure accurate hours were submitted to the PBJ. 3.A new corporate reporting structure was created to ensure the capture of salary individuals with appropriate CMS documentation to ensure proper capturing of all hours worked for PBJ. A conference call was held on 1/19/2024 to review this new	01/26/2024

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	triggered. Failure to have licensed nursing coverage 24 hours/day, triggered. The infarction dates for failure to have Licensed Nursing Coverage 24 hours/day: 7/1/23, 7/2/23, 7/15/23, 7/15/23, 7/29/23, 7/30/23, 8/12/23, 8/20/23, and 9/2/23. A record review on 1/10/24 at 11:28 of the following hours worked (clocked in/out) indicated, 7/1/23, 7/2/23, 7/15/23, 7/15/23, 7/29/23, 7/30/23, 8/12/23, 8/20/23, and 9/2/23 all had Licensed nursing coverage 24 hours/day but was not accurately reported to the PBJ. An interview on 1/10/24 at 1:03 PM with Director of Nursing and Regional Nurse Consultant indicated, they do not report all of the hours to the PBJ, especially if they are salary positions. When a salary employee would work 16 hours then the facility would report they worked 8 hours. The facility knew the problem of reporting, but the home office did the reporting to the PBJ. A currently facility policy, Staffing, was provided by the Director of Nursing on 1/10/24 at 1:03 PM. The policy indicated..." Direct care staffing information per day (including agency and contract staff) is submitted to payroll-based journal system on the schedule specified by CMS, but no less once a quarter...."		process with all Executive Directors, HR managers, and Business office managers. **4.QAPI abuse tool will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/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**="" b="">	