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	04/21/2022

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 IN00376670, IN00377095, and IN00377096. Complaint IN00376670 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00377095 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00377096 - Substantiated. Federal/State deficiencies related to the allegations are cited at F740. Survey dates: April 18, 19, 20, and 21, 2022 Facility number: 000250 Provider number: 155359 AIM number: 100289980 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 1 Medicaid: 50 Other: 12 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 26, 2027	F 0000		

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

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

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F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to initiate and revise care plans to prevent behaviors for 2 of 4 residents reviewed with behavioral health services (Resident P and Resident S) Findings include: 1. On 4/19/22 at 12:04 P.M., Resident P's record was reviewed. Diagnoses included, but were not limited to, Schizoaffective disorder, major depressive disorder, delusional disorders, personal history of traumatic brain injury, dementia, and generalized anxiety disorder. An admission MDS (Minimum Data Set) assessment, dated 3/17/22, indicated a BIMS (Brief Interval Mental Status) score of 5. This indicated the resident had severely impaired cognition. He'd had physical behaviors towards others and behavior symptoms not directed at others 1-3 days of the assessment. He was non-ambulatory and required supervision for locomotion on/off the unit while propelling his wheelchair.	F 0740	1. Identified residents care plans were reviewed as it relates to behaviors and updated as appropriate by the IDT 2. Residents that reside in the facility have the potential to be affected by this alleged deficient practice. The facility developed a plan to review all new admissions for historical behaviors and ensure appropriate care plans are written. Facility also developed a form for Investigations of incidents, that includes the review and update of care plans related to behaviors. 3. All managers on the IDT were educated by the Regional Social Service Director on proper care planning and review of behaviors to reduce risk of negative interactions on 5/3/2022. **4.** Audit tool Investigation Checklist will be completed within 7 days of any internal incident and IDT Care Plan Review will be completed within 1 business day	05/09/2022

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	A progress note, dated 3/10/22 at 3:32 p.m., indicated when the resident arrived to the facility and was taken to his room, he became upset and wanted to leave. He headed to the front entry way where he started kicking the front door glass windows. He eventually calmed down and went to his room. He shared his room with a roommate. An Indiana incident report, dated 3/15/22 at 3:31 p.m., indicated there was an altercation between Resident P and his roommate. Both had been watching their own TV's and became upset with each others volume. The roommate grabbed the TV remote from the resident who became upset and grabbed the roommate who in turn, hit Resident P. The residents were separated and attended to and Resident P agreed to a room move with a resident that didn't use a TV. A care plan, dated 3/16/22, indicated the resident had behaviors of being aggressive towards others who may ask him to turn down the volume of his TV. The resident had a traumatic brain injury and had indicated when he feels threatened, he may lash out. The goal was for the resident to demonstrate the ability to seek out staff support when feeling frustrated or provoked. Interventions included, but were not limited to, identify his triggers and reduce exposure to and document behaviors per behavior management program. An Indiana incident report, dated 3/28/22 at 4:01 a.m., indicated Resident P's new roommate indicated he had been hit. The roommate was found to have an abrasion to his nose and right eye. It was unclear to staff whether Resident P had caused the injury to his roommate. The roommate was removed and placed into another room for the rest of the night. Neither resident was		of new admissions. Regional Nurse Consultant/designee will review new admissions and incidents weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, 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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	able to state what had happened and the roommate indicated he wanted to go back into his room with Resident P. A care plan, dated 3/29/22, indicated the resident was at risk for negative interactions with his peers due to being territorial over his room. The goal was for the resident to have no indications of psychosocial well being problems. Interventions were: allow resident to make independent decisions when appropriate, allow resident time to answer questions and verbalize his feelings and fears, encourage resident and family involvement in care planning, increase social relationships, and when conflict arises, remove residents to a calm/safe environment and allow to vent feelings. A nurse progress note, dated 3/31/22 at 2:12 a.m., indicated Resident P approached the nurse station and told staff to call 911 because he was being held in the facility. He could not be re-directed and headed to the front door where he slammed a table against the glass on the door. He was combative with staff, threw a tissue box at a CNA (Certified Nurse Assistant), ripped the mouse out from a computer, tore the wire out of it, and threw linen off the linen cart onto the floor. He eventually calmed down, returned to his room and went to sleep in his bed. An IDT (Interdisciplinary Team) behavioral note, dated 3/31/22 at 4:25 p.m., indicated the IDT had met to review the resident behaviors from during the night. The resident hadn't remembered the incident. He indicated he was being held at the facility and wanted to leave to be closer to his son. He was pleasant and friendly during the afternoon but did demand that he be given a private room. He was to be seen by the psychiatric NP on the next routine visit and staff			

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	would continue to observe his behaviors. There were no revisions made to the care plan for how to manage the residents territorial behaviors while having a roommate and not being in a private room. An Indiana incident report, dated 4/4/22 at 12:30 a.m., indicated Resident P's roommate was in bed and heard yelling out. Staff entered the room and found Resident P sitting in his wheelchair on his roommates side of the room. He was agitated because he couldn't find his glasses. The roommate had scratches to his face. Resident P was directed out to the nurses station for direct supervision. Focused charting for physical aggression was initiated on 4/4/22 at 6:15 a.m. and indicated the resident had caused scratches to his roommate's face. He had been agitated because niether he nor staff were able to find his glasses. He was brought out to the nurses station in his wheelchair where he attempted to throw his chair over the nurses station desk and tried to grab a computer monitor screen. The resident was monitored and kept away from other residents. A care plan, dated 4/4/22, indicated the resident exhibited behaviors of cursing at staff when he didn't get his perceived needs met immediately. His behaviors could escalate from verbal to physical. The goal was for the resident to demonstrate the ability to seek out staff support when feeling frustrated or provoked. Interventions included provide positive feedback for good behavior, provide personal space, and remove resident from the situation. A nurse progress note, dated 4/4/22 at 12:05 p.m.,			

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	indicated the resident had moved rooms. He was moved to a room with a different roommate. A care plan, dated 4/5/22, indicated the resident exhibited behaviors of getting upset when he had a roommate or saw peers in his room. Due to his short term memory, he still believed his room was his apartment. The goal was for the resident to demonstrate the ability to seek out staff support when feeling frustrated or provoked. Interventions included, but were not limited to, place a name identifier on his closet space. The care plan did not indicate how staff were to keep the resident's new roommate safe from physical altercations as he was placed in a room with another resident. 2. On 4/19/22 at 10:09 A.M., Resident S's record was reviewed. Diagnoses included, but were not limited to, schizophrenia, dementia, anxiety, depression, restlessness and agitation, sexual disorders, and violent behavior. The resident admitted to the facility following a psychiatric hospital stay. A hospital history and physical indicated the resident had been living at a long term care facility where he had begun to display physical aggression towards staff and residents, intrusive and impulsive behaviors, had slapped a female nurse and ran over her foot with his wheelchair. The resident had intimidated nursing staff with verbal aggression and used racial slurs. He had gone into female resident rooms at night and sat on their beds watching them sleep. While hospitalized, the resident had been found nude in bed with a female resident and had been started on medication. An admission MDS assessment, dated 2/8/22,			

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	indicated a BIMS score of 8-moderately impaired cognition. The resident had no behaviors, was ambulatory with a walker, and required supervision when up in his room and in the hallways. A care plan, dated 3/21 and revised 4/12/22, indicated the resident exhibited behaviors of yelling and screaming. He would get louder and his words more garbled as he got upset if staff were unable to understand him. He could exhibit abusive language, cursing, and threatening behaviors. The goal was for the resident to demonstrate the ability to seek out staff support when feeling frustrated or provoked. Interventions included, but were not limited to, provide resident with personal space, remove him from a situation, listen to the resident needs, and approach him in a calm and friendly manner. An Indiana incident report, dated 4/4/22 at 6:01 p.m., indicated Resident S was alleged to have inappropriately touched a female peer on the thigh. The investigation indicated the resident had touched the female peer on the thigh but not on her private parts. There was no behavioral care plan initiated prior to the incident occurring nor was one initiated following the incident to prevent further occurrences with other female peers. On 4/19/22 at 11:27 A.M., the Social Services Director (SSD) was interviewed. She indicated behavioral care plans should indicate behaviors that affect the resident and others to prevent negative interactions and catastrophic reactions from occurring. When new behaviors were identified, a behavioral care plan should be put in place and the behavior monitored and care plan			

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	revised as indicated. A current facility policy, titled "Mood and Behavior Management", was provided by the Administrator on 4/19/22 at 1:00 p.m. The policy stated the following: "It is the policy of [facility] to provide interventions for all residents with behavioral and/or mood indicators that may be problematic or distressing. Residents are provided a supportive environment that is aimed at prevention, relief and/or accommodation of their behavior and/or mood in addition to interventions that are specific to the resident's individualized needs. Procedure: A care plan should be initiated for any behavioral symptom that affects, or has the potential to affect the resident or others...." This Federal tag relates to Complaint IN00377096. 3.1-43(a)(1)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure and maintain a clean and functional environment for 13 shared bathrooms affecting 44 residents residing in the facility. Findings include: On 4/19/22 at 10:45 A.M., an environmental tour was completed with the Environmental Services Managers (EVS). The following shared bathrooms were observed: A bathroom shared between 4 residents and	F 0921	1. Management staff was in serviced on 5/4/2022 on daily rounds and identify issues and address with housekeeper to ensure we maintain compliance. 2. Residents that reside in the facility have the potential to be affected by this alleged deficient practice. The facility developed a daily cleaning schedule. The Executive Director/Designee will monitor daily for compliance. 3. All staff was educated	05/09/2022

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	located between rooms 101-102, was observed with brown black debris on the floor around the stool and the stool caulking was rust colored. There were torn non-skid strips on 3 sides of the stool. The walls had dried brown debris and the corners of the bathroom had dried black debris in them. The toilet seat had dried brown debris and there was BM (bowel movement) in the toilet bowl. A bathroom shared between 3 residents and located between rooms 103-104 had brown debris on the walls and black debris in all corners of the bathroom. A bathroom shared between 4 residents and located between rooms 105-106 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. A bathroom shared between 4 residents and located between rooms 107-108 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored. A bathroom shared between 4 residents and located between rooms 110-111 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored. A resident in room 111 indicated the bathroom never got cleaned and was unsanitary. A bathroom shared between 4 residents and located between rooms 112-113 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored. A dirty adult brief laid on the floor next to the bed of a resident		cleaning resident bathrooms and providing a sanitary environment on 5/4/2022 by the Executive Director/designee. 4. QAPI tool Weekly Assessment (attached) will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. 5 times per week manager inspections on Magic Maker Rounds of bathrooms for 4 weeks and 3 times per week thereafter. The system to report any issues are either a grievance form by the resident or documented on the rounds slip and discussed in the morning meeting depending on the issues found. 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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	in room 113. Another resident in room 113 indicated the bathroom never got cleaned and believed the facility should be using "Lysol" to clean the germs. A bathroom shared between 4 residents and located between rooms 114-115 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored. A bathroom shared between 2 residents and located between rooms 116-117 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored and the toilet bowl had black stains. A bathroom shared between 2 residents and located between rooms 124-125 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored and the toilet bowl had black stains. A bathroom shared between 2 residents and located between rooms 126-127 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. There was yellow amonia smelling liquid on the vanity near the sink. A bathroom shared between 4 residents and located between rooms 129-130 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored. A bathroom shared between 4 residents and located between rooms 137-138 had brown dried streaks on the walls and black debris in all 4			

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	corners of the bathroom. Caulking around the toilet stool was rust to black colored. The toilet bowl was black and contained BM. The toilet seat had dried brown streaks. A bathroom shared between 3 residents and located between room 139-140 had brown dried streaks on the walls and black debris in all 4 corners of the bathroom. Caulking around the toilet stool was rust to black colored. The toilet bowl was black and contained BM. A commode seat sat over the toilet bowl and had brown streaked debris on it . On 4/19/22 at 11:35 A.M., in an interview, the EVS Manager indicated he currently had 1 other employee beside himself in the department. The facility normally staffed 3-4 housekeepers but he was having difficulty recruiting staff despite numerous attempts. The facility was replacing the flooring in all the bathrooms but would take time to complete. This Federal tag relates to Complaints IN00376670 and IN00377095. 3.1-19(e)			