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	12/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00367878 and IN00367937. This visit included a COVID Focused Infection Control Survey Complaint IN00367878 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00367937 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Survey date: December 9, 2021 Facility number: 000250 Provider number: 155369 AIM number: 100289980 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 2 Medicaid: 43 Other: 10 Total: 55 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 9, 2021	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and			

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

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	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 prevent agency staff from yelling at 1 of 3 residents reviewed. (Resident E) Findings include: In an interview on 12-9-21 at 8:45 A.M. LPN 1 indicated she heard yelling coming from the West hall. She indicated she went down the hall with CNA 2 and CNA 3. When they arrived, Resident E was yelling at about an undisclosed resident having taken his hat. As his gesturing and yelling began to escaalte, CNA 2 began to yell back at Resident E using profanity. Staff attempted to intervene with CNA 2, CNA 3 even stepped between them, but interventions were unsuccessful. CNA 2 began to threaten Resident E. Resident E was finally redirected into his room. CNA 2 was sent home. In an interview on 12-9-2021 at 9:32 A.M., the DON (Director if Nursing indicated CNA 2 was an agency CNA. She indicated the CNA would	F 0600	**F 600** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E was redirected without further concern. Social services assessed for psychosocial distress, none noted. C.N.A #2 was an agency C.N.A and was immediately removed from the facility. The agency was notified that C.N.A. #2 was not to return to the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All interviewable residents were assessed using the abuse questionnaire, no findings. All non-interviewable residents were	12/10/2021

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	no longer be on the facility's roster of acceptable people to be working in the facility. She indicated the agency keeps a record of abuse training or each staff person, but she had no access to the training. A review of progress notes indicated there was no note to review regarding the yelling occurrance. A review of pscy notes indicated Resident E continued to be seen by the psyc provider without residual effects from the occurrance. 3.1-27(a)(b)		assessed per head to assessment per licensed nurse- no findings. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Staff inserviced on abuse policy and prevention by the Executive Director/Designee on 12/10/21. All staff will be educated upon hire and at a minimum annually on the Abuse Prevention Policy **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Resident Abuse Policy 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 **12/10/21**	