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	08/28/2023

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 IN00414691, IN00415268 and, IN00415764. Complaint IN00414691 - No deficiencies related to the allegations are cited. Complaint IN00415268 - No deficiencies related to the allegations are cited. Complaint IN00415764- Federal deficiencies related to the allegations are cited at F600. Survey date: August 24 and 28, 2023 Facility number: 000250 Provider number: 155359 AIM number: 100289980 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 1 Medicaid: 59 Other: 6 Total: 66 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 30, 2023	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

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

Gregg Fuller | Executive Director | 09/08/2023

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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	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 facility abuse protocols were implemented for 1 of 3 incidents reviewed. (Resident B) Findings include: On 8/24/2023 at 9:45 AM, a review of a facility's self-reported incident of abuse reported to the Indiana Department of Health (IDOH) on 8/22/2023 indicated an incident of abuse had occurred on 8/22/2023 at 7:01 A.M. The report named Resident B and RN (Registered Nurse) 1 as the persons involved. The description of the incident indicated RN 1 told Resident B to stop crying and was not taking care of Resident B's needs. Resident B became upset, stood up to the nurse's desk and pushed the computer monitor over. RN 1 then reacted by slapping Resident B on the cheek. On 8/24/2023 at 10:08 AM, the Administrator provided the facility's investigation of the abuse incident. The administrator indicated they had substantiated the abuse by the nurse after they viewed the camera video.	F 0600	1. Social services assessed for psychosocial distress, none noted. RN identified was removed from the facility. The RN was not to return to the facility while investigation was conducted. **2. Interviewable residents were assessed using the abuse questionnaire, no findings. All non-interviewable residents were assessed per head to assessment per licensed nurse-no findings.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, bi-monthly X 2 and monthly X 4 months by Executive**	08/29/2023

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	On 8/24/2023 at 1:30 P.M., A review of Resident B's records began and indicated diagnosis of paranoid personality disorder, intellectual disabilities, vascular dementia with severe anxiety and agitation, delusional disorders, major depressive disorder, and chronic pain syndrome. Resident B's current MDS (Minimum Data Set) Assessment dated, 7/27/2023, indicated a BIMS (Brief Interview for Mental Status) Score was 09; moderately impaired cognition. The MDS assessment indicated during the time period of the assessment, the resident had wandered 1-3 days and the behavior had worsen from the prior assessment. The Functional Status and Activity of Daily Living (ADL) assistance required, indicated the resident required extensive assistance of 1 person to transfer but limited assist of 1 to walk. Their balance was not steady and could only stabilize with assistance of staff. The MDS also indicated a wheelchair was used for mobility. Resident B's progress notes indicated the following: On 8/22/2023 at 12:54 P.M., a Social Service note indicated the Social Service Director (SSD) had spoken with Resident B in their room. Resident B indicated they felt safe at the facility with staff. Resident B displayed signs of agitation and sadness by yelling out and crying. The resident reported they were emotional because their roommate would not talk to them since being kicked by the resident. Resident B stated they were not upset with facility staff, just wanted their roommate to forgive them. On 8/23/2023 at 9:17 A.M., an IDT (Interdisciplinary Team) note indicated the Team met to discuss the incident between the staff		**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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	member and the resident. The incident indicated the resident was struck in the face by a staff member. The resident had no complaints of pain or injury on the initial assessment or the follow-up. The resident continued daily routine without changes, was participating in therapies and activities, and showed no hostility or fear towards other residents or staff members. Progress notes on 8/24/23 and 8/25/23 by IDT and SSD indicated Resident B continued typical daily routine, attended activities, showed no hostility or fear towards other residents or staff., had no displayed signs of psychosocial distress and was at their baseline behaviors. Resident B's Care Plan initiated on 1/24/2023 with a Revision Date of 2/8/23 indicated Resident B exhibits behavior related to anxiety. Resident B would ask repetitive questions and become obsessive with needs, obsessive with attention. Resident would also become impulsive when needs are not addressed at that very second. Resident would get tearful and lash out when feeling not enough attention was given. Interventions included the following: Allow resident to vent feelings and needs. Approach resident in a calm and friendly manor. Assess resident's needs including comfort level, pain and treat as indicated. Explain to resident what you were going to do before initiating task. If resident becomes combative or resistive, postpone care/activity and allow resident to regain their composure, re-approach as needed. Listen to resident's needs and adjust plan as appropriate. Maintain a safe environment for the resident. The facility's investigation of the abuse incident regarding Resident B indicated RN 1 was suspended, the investigation began and included			

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	interviews with staff and residents. Written statements by staff on duty were collected. CNA (Certified Nursing Aide) 2's statement indicated on the morning of Monday, August 21st, she witnessed the nurse, RN 1 "smack" Resident B in the face at the nurses station. Resident B was agitated due to the nurse teasing the resident and things escalated. The statement was signed by CNA 2. The email sent to the facility DNS (Director of Nursing Services) from RN 1, dated 8/23/2023 at 5:31 AM., contained RN 1's written statement. The statement indicated on 5/21/23 around 5:20 A.m., Resident B was yelling to get up in their wheelchair. A CNA assisted Resident B up in the wheelchair and brought them out to the nurses station. Resident B wanted something for their foot. RN 1 indicated she administered Tylenol ordered for them. RN 1 indicated she had a hard time understanding Resident B. The CNA reported Resident B wanted the foot dressing (bandage) changed, even though it was intact. RN 1 indicated she changed the dressing, and applied the pressure relieving protector pillow. RN 1 seen a sock was missing. Resident B became mad and wanted the sock now. RN 1 indicated she told the resident she would get the socks when she finished entering computer information. She indicated Resident B walked to the computer, lifted the monitor as if to hit her with it. She indicated she told the resident to "not be a jerk" and please do not break the facility's equipment. She wrote, all she could think was to connect with the resident so she cupped Resident B's left cheek with her right hand. Resident B gave no eye contact. RN 1 indicated she did not know what set the resident off that morning. The follow-up to the facility's incident			

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	investigation conclusion reported to IDOH on 8/24/2023 indicated the following: The nurse reacted to the resident pushing over the monitor and made contact with the resident's face. The resident had become upset about their foot. The nurse had stated she was going to have day shift change the dressing, but a short time later she did the dressing change with no concerns. Resident B continued to be upset per the aide (CNA), the nurse not addressing the resident's concerns. The resident stood up at the nurses' station stating they wanted something to be done with their foot. The resident then pushed over the computer monitor onto the desk. The nurse grabbed the monitor, then reached out to the resident and made contact with the resident's cheek. RN 1 was suspended pending investigation, and was later terminated. Abuse in-servicing was initiated for all staff. The resident was assessed and no injury was noted. Multiple residents were interview with no concerns. There were no skin issues of unknown origin for residents in the past 2 weeks. The counselor will meet with the resident to continue to follow up for any psychosocial needs. Resident B had not shown any adverse side effects from the incident and continued in their normal daily routine. Resident B had not mentioned the incident further. The facility's Care Team Member Corrective Action Form indicated Investigatory Suspension pending determination for RN 1. The infraction date was listed as 8/21/2023. The Infraction/Policy Violation was related to resident abuse, neglect, or misappropriation. Description of Violation: RN 1 was witnessed on camera after another Care Team Member/Staff called the Administrator, the DNS and reported abuse. RN 1 was witnessed on camera to have slapped a resident, continued to taunt and then stick her tongue out at the			

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	resident. Corrective Action: RN 1 would be placed on suspension. The form indicated RN 1 was notified by phone of the suspension. The form was signed by the DNS and witnessed by LPN 3. In an interview on 4/24/2023 at 5:00 P.M., the DNS indicated CNA 2 had called the Administrator on 8/22/2023 in the morning before they arrived at the facility. CNA 2 reported Nurse 1 had hit Resident B in the face. The DNS indicated the Administrator was at the facility when she arrived and had begun the investigation. She indicated she notified RN 1 she was suspended pending the investigation of abuse. She indicated they viewed the camera video. The video indicated RN 1 was observed to slap Resident B on the face. She indicated RN 1 was terminated after the video was viewed. A current facility policy, titled, Abuse Prevention Program, with Revision Date of March 2021, was provided by the Administrator on 8/24/2023 at 10:08 A.M., indicated, "...Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff...Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents...Abuse - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse,			

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	physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...." This Federal tag relates to Complaint IN00415764. 3.1-27(a)(b)			