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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of South Bend	52654 N Ironwood Rd South Bend, IN 46635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0678

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31719

Based on record review and interview, the facility failed to immediately initiate Cardiopulmonary Resuscitation (CPR) in accordance with the resident's advanced directives for 1 of 3 residents reviewed for facility discharge. (Resident D) This deficient practice resulted in CPR not being provided immediately when staff found the unresponsive resident and the resident died .

The Immediate Jeopardy began, on [DATE] at 5:25 P.M., when staff identified Resident D was unresponsive and failed to immediately initiate CPR. The Administrator and the Interim Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on [DATE] at 12:46 P.M. The Immediate Jeopardy was removed, on [DATE], but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.

Finding includes:

On [DATE] at 11:13 A.M., a review of the clinical record for Resident D was conducted. The resident was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, necrotizing fasciitis (flesh eating disease) to a sacral wound, insulin dependent diabetes, End Stage Renal Disease requiring hemodialysis, and a history of a cardiac arrest.

A Physician's Order, dated [DATE] at 1:45 P.M., indicated the resident was a Full Code (Medical personnel will do everything possible to save your life in a medical emergency including CPR.

A Care Plan, dated [DATE], indicated the resident established advanced directives and wished to be a full code. The interventions included, but were not limited to, .Notify MD [Medical Doctor] and representative of changes in the resident condition/status

A Care Plan, dated [DATE], indicated the resident was at risk for complications, related to medical conditions, medications and treatments. The interventions included, but were not limited to, observe for signs/symptoms of complications and assessments as indicated.

An Admission Minimum Data Set (MDS) Assessment, dated [DATE], indicated the resident was cognitively intact, had an unstageable wound, and did not have a condition which may have resulted in a life expectancy of less than six months.

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A MD/NP (Nurse Practitioner) Progress Note, dated [DATE] at 2:30 P.M., indicated the resident was sent to the emergency room (ER) for an evaluation due to persistent hyperkalemia (high potassium levels). The resident refused dialysis and was provided with education. The resident returned to the facility on [DATE]. An Interdisciplinary Team (IDT) Progress Note, dated [DATE] at 12:07 P.M., indicated the resident was at risk for nutritional issues due to weight loss and a wound to her coccyx. The resident triggered for a significant weight loss in the past 30 days, upon return from the hospital, and her wound improved. The resident had been refused dialysis treatments and/or requesting shorter dialysis treatment times. The Medication Administration Record (MAR) for [DATE], indicated the resident was administered Reglan (used for GERD - gastroesophageal reflux disease) 5 mg (milligrams) before meals and at bedtime. The resident accepted the 8:00 A.M., 11:00 A.M and 5:00 P.M. doses, on [DATE]. The resident did not have an order for anti-nausea medication on her MAR. A Nursing Progress Note, dated [DATE] 5:03 P.M., indicated the resident was sent to the emergency room for an evaluation of a lesion near her dialysis port. She returned to the facility the same day. An IDT Progress Note, dated [DATE] at 2:22 P.M., indicated the IDT reviewed Resident D due to multiple lesions noted on her face and slightly above the dialysis port. The resident received topical and oral antibiotic due to cellulitis. The NP reviewed the resident's recent laboratory tests, noted the resident's WBCs (white blood cells) counts were elevated, and gave an order for the resident to be sent to the ER again. There was no nursing progress note to indicate the resident had returned to the facility; however, the resident's census documentation indicated the resident had returned from the hospital on [DATE]. A Nursing Progress Note, dated [DATE] at 5:31 A.M., indicated the resident received IV antibiotic for an infection and did not experience any side effects from the medication. The note also indicated the resident's vital signs were within her normal limits. A Nursing Progress Note, dated [DATE] at 12:00 A.M., indicated the resident experienced an unwitnessed fall. The resident was assessed, the vital signs were checked, range of motion (ROM) was intact, and no injuries were noted. A Neurological Assessment check sheet was initiated. The resident denied pain or discomfort. The physician and the resident's family were notified of the fall. A Nursing Progress Note, dated [DATE] at 6:08 A.M., indicated the resident's vital signs were within normal limits and the resident denied any pain related to the fall and monitoring would continue. A form titled, Neurological Assessment for Resident D indicated the neurological assessments started on [DATE] at 11:45 P.M. and continued until [DATE] at 6:00 A.M. The form indicated the resident did not have her neurological status assessed at 7:00 A.M., 8:00 A.M., 11:00 A.M. and 3:00 P.M., as scheduled for an unwitnessed fall. There were no additional Nursing Progress Notes, on [DATE] until 6:18 P.M., for Resident D. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing Progress Note, dated [DATE] at 6:18 P.M., indicated the resident was found unresponsive at about 5:25 P.M., .by the aide while passing dinner trays. Sternal rub attempted. Res [resident] set on the floor, CPR initiated. 911 called did CPR on the patient for about 25 minutes no pulse or breathing post CPR. EMS did stop CPR, pronounced dead (sic) The resident's family member was present at the time of death. During an interview, on [DATE] at 1:15 P.M., QMA 2 indicated Resident D resided on the North unit. QMA 2 indicated she was assigned to the North unit, on [DATE], during the evening shift. QMA 2 indicated she reported to RN 3 that Resident D complained of stomach pain, vomited phlegm throughout the day, and wanted to go the ER. QMA 2 indicated the resident yelled out most of the day for assistance with the phone and frequent position changes. QMA 2 indicated RN 3 was the only licensed nurse in the facility and was assigned to another unit on [DATE]. QMA 2 indicated RN 3 advised her to administer nausea medication and monitor the resident's response. QMA 2 indicated she checked on Resident D at an unknown time and the resident seemed fine. QMA 2 indicated she overheard the resident say she wanted to wait to go to the ER. QMA 2 indicated the resident's family was updated during the afternoon that the resident's stomach pain continued, the resident asked to be transferred to the ER, and family member wanted staff to wait until their arrival at the facility to send the resident. QMA 2 indicated CNA 4 was passing supper trays and alerted QMA 2 to the resident's yelling. QMA 2 indicated she instructed CNA 4 to continue passing supper trays and QMA 2 would check on Resident D. QMA 2 indicated the resident's family member and QMA 2 entered the resident's room at the same time and found the resident sitting on the side of bed and observed the resident was not breathing. QMA 2 indicated she ran to the nurse's station to determine the resident's code status, instructed CNA 4 to start CPR, and left the North unit to get RN 3 from the South unit. QMA 2 indicated upon her return to the North unit she observed Resident D lying on the floor and CNA 5 was performing CPR. QMA 2 indicated Emergency Medical Services (EMS) staff arrived, the EMS staff took over CPR, and eventually pronounced Resident D deceased . QMA 2 indicated she could not provide a specific timeline of events. During an interview, on [DATE] at 3:17 P.M., RN 3 indicated she was the only licensed nurse in the facility on [DATE]. RN 3 was going about her duties when QMA 2 came to her unit, stating she had called a code. RN 3 indicated she took off running down to the other unit. When she arrived at the resident's room, Resident D was in a sitting position on her bed, without respirations/pulse and had not been receiving CPR. Another staff member helped her position Resident D on the floor so CPR could be initiated. QMA 2 grabbed the crash cart on her way back to the unit. RN 3 indicated QMA 2 told her the resident requested to be sent to ER earlier, but indicated the resident did not exhibit any new symptoms. RN 3 indicated she observed the resident several times throughout the day. RN 3 was told the resident had been visiting with her grandparents and after their visit, was asking again to go to ER. It was RN 3's understanding a non-emergent local transport ambulance and the resident's family member was called. RN3 indicated the resident's family member was in the room when she entered and assessed the resident, brought resident to the floor and had a staff member start CPR. Although RN 3 indicated she observed Resident D several times throughout the day, there was no documentation to support her statement. During an interview, on [DATE] at 3:55 P.M., the Maintenance Director indicated he measured the distance between the North and South nursing station to be 240 feet. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on [DATE] at 10:14 A.M., CNA 5 indicated he worked the day Resident D passed away but had clocked out for the day at approximately 3:00 P.M. and was not on duty during the evening meal. He indicated the resident told him before lunch she was not feeling well and wanted to go to the ER. He communicated the resident's request to QMA 2. CNA 5 indicated the resident was not using her call light that day and would just call out QMA 2's name repeatedly. He assisted the resident with numerous things during the day. Resident D told CNA 5 she thought the dialysis treatments were making her sick. During an interview, on [DATE] at 10:19 A.M., the Nurse Practitioner indicated she received three phone calls from the facility, on [DATE] regarding Resident D. The NP indicated she was notified of the resident's unwitnessed fall without injury just after midnight, of normal neurologic assessmetns throughout the night at 6:00 A.M., and of the resident's death during the evening. The Nurse Practitioner indicated the facility did not notify that the resident requested to go to the hospital on [DATE]. The Nurse Practitioner indicated Resident D was usually very resistant to go to the hospital. The facility did nott request an order to send the resident to the hospital on [DATE]. During an interview, on [DATE] at 10:32 A.M., CNA 4 indicated she worked, on [DATE] from 7:00 A.M. to 10:00 P.M., on the North unit. Resident D called out several times for assistance and told her she wanted to go to the ER sometime before lunch. CNA 4 indicated she told QMA 2 of the resident's request. Sometime after lunch, the resident's grandparents visited and brought the resident food; however, the resident did not eat much of it. During the evening, while CNA 4 was passing the supper trays, Resident D was yelling out again for assistance. QMA 2 instructed her to continue to pass the meal trays, as QMA 2 would be going into the resident's room shortly. Then CNA 4 observed QMA 2 running out of Resident D's room and told her to call a code blue. CNA 4 indicated she thought she was supposed to call for hel from the other unit because Resident D needed CPR. CNA 4 called the code on the facility overhead paging system, as QMA 2 ran down the hallway towards the South nursing unit. CNA 4 indicated she did not start CPR but followed all the other staff members, when they arrived on the North unit. CNA 4 entered the resident's room, and assisted other staff members to transfer the resident from her bed to the floor to start CPR. She was unable to name the staff member who started CPR. She indicated the ambulance service was at the facility shortly after and they took over CPR on the resident. CNA 4 left the room to continue passing the evening meal trays. During an interview, on [DATE] at 10:42 A.M., the local non-emergency EMS service staff indicated their service received a call, from the facility for an ambulance at 7:11 P.M. The EMS service indicated their dispatcher advised the facility to call 911 for immediate service, and they did not go to the facility on [DATE]. During an interview, on [DATE] at 12:56 P.M., the Interim Director of Nursing (DON) indicated she was the DON, on [DATE], and was on call for any questions/concerns the staff might have. The Interim DON indicated she received a call from RN 3 at 7:21 A.M., indicating Resident D was requesting to go to the ER. The Interim DON indicated she told RN 3 to send the resident to the ER if that was what the resident requested. The Interim DON indicated she did not hear anything further from RN 3, until RN 3 contacted her to tell her they were performing CPR on Resident D. CPR Facts & Stats article was retrieved, on [DATE], from the American Heart Association website at www. cpr.heart.org. The article indicated .CPR is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances for survival (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the Administrator provided a form titled, An Indiana State Department of Health Certificate of Death The form indicated the date of Resident D's death on [DATE] at 6:00 P.M., and the cause of death was pulseless electrical activity. On [DATE] at 3:28 P.M., the DON provided a policy titled, Cardiopulmonary Resuscitation (CPR), dated [DATE], and indicated the policy was the one currently used by the facility. The policy indicated Purpose: to ensure the facility provides emergency basic life support immediately when indicated The Immediate Jeopardy that began, on [DATE], was removed, on [DATE], when the facility completed nursing staff education/in-service on CPR-,basic process with emphasis on immediately implementing CPR, in accordance with resident's advanced directive, with one staff member calling the code, while another staff member dials 911 and another staff member documenting code process, mock codes completed for each shift, resident code status and Care plans updated, The Immediate Jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because not all staff had been educated on CPR audits were ongoing to review Progress Notes for a change of condition and/or requests to be sent to ER. This citation relates to Complaint IN00437316. 3XXX,d+[DATE](a)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31719

Based on observation, interview and record review, the facility failed to ensure there were a sufficient number of licensed nurses (RN/LPN) to provide care and services to 1 of 2 nursing units (Skilled/Rehabilitation Unit.) This directly affected 5 of 10 residents reviewed for care needs. (Resident D, B, H, L, and K)

See F678 for additional information regarding Resident D.

See F755 for additional information regarding Residents B, L, K and D

Finding includes:

On [DATE] at 11:13 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: necrotizing fasciitis (flesh eating disease) to a sacral wound, insulin dependent diabetic, End Stage Renal Disease with hemodialysis and history of a cardiac arrest.

A Care Plan, dated [DATE], indicated the resident was at risk for complications, related to medical conditions, medications and treatments. The interventions included, but were not limited to, observe for signs/symptoms of complications and assessments as indicated.

A Progress Note, dated [DATE] 12:08 A.M., indicated the resident had an unwitnessed fall and neurological checks were initiated.

A Progress Note, dated [DATE] at 6:08 A.M., indicated the resident's vital signs were within normal limits and resident denied pain related to the fall and monitoring would be continued.

A form titled Neurological Assessment for resident D indicated assessments started at 11:45 P.M. on [DATE] and continued until [DATE] at 6:00 A.M. The form indicated the resident did not have her neurological assessments completed at 7:00 A.M., 8:00 A.M., 11:00 A.M. and 3:00 P.M., as per the required schedule for an unwitnessed fall.

There were no additional Progress Notes on [DATE] until 6:18 P.M., for Resident D.

A Progress Note, dated [DATE] at 6:18 P.M., indicated the resident was found unresponsive at about 5:25 P.M., .by the aide while she was passing dinner trays. A Sternal rub was attempted. The resident was moved to the floor, CPR was initiated. 911 was called, CPR performed on the patient for about 25 minutes no pulse or breathing post CPR. EMS stopped CPR and the resident was pronounced dead at 6:00 P.M. Her family member was present in the room.

A PBJ (Payroll Based Journal) staffing Data Report for Quarter 2 ([DATE]- [DATE]) indicated One Star Staffing and Excessively Low Weekend Staffing had triggered for the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Midnight Census Report, dated [DATE], indicated there were 76 residents in the facility for [DATE]. The RN/LPN Staffing Schedule for [DATE], indicated there was 1 RN working from 6:30 A.M. to 6:00 P.M. and 2 LPN's working from 6:00 P.M. to 6:00 A.M. The Per Patient Day (PPD) for [DATE] was calculated by the following formula: RN/LPN and Hours scheduled equaled 36 hours divided by census of 76 residents = 0.473 This was below the number the facility had deemed were necessary to provide care for the residents. A Midnight Census Report, dated [DATE], indicated there were 74 residents in the facility for [DATE]. RN/LPN Staffing Scheduled for [DATE], indicated the day shift had 1 RN from 6:00 A.M. to 6:00 P.M., and 1 LPN from 7:30 A.M. to 3:30 P.M. and the night shift had 2 LPNs for 12 hours. The Per Patient Day (PPD) for [DATE] was calculated by the following formula: RN/LPN and Hours scheduled equaled 44 hours divided by census of 76 residents = 0.594 PPD. This was below the number the facility had deemed were necessary to provide care for the residents. A Facility Assessment Tool, dated ,d+[DATE] through ,d+[DATE] was provided, by the Administrator, on [DATE] at 11:02 A.M. The Assessment tool indicated the following: .Total Number Needed or Average Range was 1.2 of licensed nurses needed to provide direct care. This included Registered Nurses (RN) and Licensed Practical Nurses (LPN). During an interview on [DATE] at 10:10 A.M., Resident C indicated he believed nursing staff did not check his blood sugar levels as often as they should, but he could not say exactly when blood sugar levels had not been tested . During an interview on [DATE] at 10:10 A.M., Resident H indicated the facility sometimes had glitches where he did not get his medication on time, but it did not happen very often. The resident indicated the facility normally staffed his unit with 1 Qualified Medication Aid (QMA) and 1 Certified Nursing Assistant (CNA). He had heard the facility was going to start staffing with an additional nurse so 1 QMA did not have so much to do. During an interview on [DATE] at 10:27 A.M., Resident B indicated the care at the facility was terrible, starting at his admission on [DATE]. Medications were frequently late or not given, staff did not answer calls lights timely, and staff did not change his bedding for 6 days. During an interview, on [DATE] at 12:18 P.M., CNA 6 indicated she worked every other weekend, usually with a QMA, on the North unit (skilled/rehab unit), however the last few weekends there had been a RN/ LPN working. CNA 6 indicated if there was only one CNA and a QMA working, it was really tough during a meal time due to residents needing different items with meals and the QMA was busy passing medications. She indicated no showers were scheduled for 2nd shift to complete. Residents on the Skilled unit sometimes needed one on one care and it made it hard and staff werer pulled from other duties to ensure their safety. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on [DATE] at 12:31 P.M., the North Unit Manager indicated a QMA was usually scheduled with 1 CNA on the North skilled/rehab unit and she would frequently need to step in to assist the CNA plus pass medications and complete assessments since the unit was a Skilled/Rehab Unit. During an interview, [DATE] at 12:45 P.M., with the Facility Scheduler whom had taken over scheduling a month ago, she had been instructed to schedule a nurse, if possible, on the North Unit. The Scheduler indicated if she was unable to obtain a RN or LPN to work the unit, the Unit Manager would have to assist the QMA with duties, out of her scope of practice, but this did not apply on the weekends as the Unit Manager would not be working. A few weeks ago, she had been reinstructed to have a licensed RN or LPN on the North Unit at all times. There was no policy provided regarding scheduling of staff except the Facility Assessment. This citation relates to Complaint IN00437316 and IN00436970. 3XXX,d+[DATE](a) 3XXX,d+[DATE](b)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34966 Based on record review and interview, the facility failed to ensure residents received medications and treatments in accordance with physician orders and per facility policy for 4 of 6 residents reviewed for nursing services, (Residents B, L, K & D). Findings Include: 1. A record review was completed for Resident B on 7/11/24 at 12:28 P.M. The diagnoses included, but were not limited to, cellulitis of right lower limb, type 2 diabetes, chronic obstructive pulmonary disease, atrial fibrillation, heart failure, stage 2 pressure ulcer. An Admission Minimum Data Set (MDS) assessment, dated 5/22/24, indicated Resident B was cognitively intact, was admitted with one stage 2 pressure area and one stage 4 pressure area.and received 7 days of insulin injections in the previous 7 days of the assessment period. The current Physician's Orders included: -Accu Check 3 times daily before meals and at bedtime related to diabetes, ordered 5/17/24 with no end date. -Insulin Aspart Injection solution 100 unit/ml per sliding scale 3 times daily, ordered 5/16/24 with no end date. -Hydrocodone-Acetaminophen 10-325 MG, give 1 tablet by mouth 3 times a day, ordered 5/15/24 with no end date. -Cleanse right posterior thigh with wound cleanser, pat dry, apply Collagen, then cover with dry dressing daily and as needed. -Apply house barrier cream to buttocks, coccyx, and peri-area every shift. Resident B's Medication and Treatment Records indicated, from 6/1/24 to 7/11/24, the resident did not receive the following as ordered: -Accucheck blood sugar checks on 6/5/24 at 10:00 A.M. 3:00 P.M., 6/7/24 at 10:00 A.M., 3:00 P.M., 6/11/24 at 7:00 P.M., 7/2/24 at 10:00 A.M., 3:00 P.M., 7/3/24 at 3:00 P.M., 7/6/24 at 10:00 A.M. and 3:00 P.M., and 7/8/24 at 3:00 P.M. -Medication-Insulin Aspart injection solution per sliding scale on 6/5/24 at 10:00 A.M. and 3:00 P.M., 7/7/24 at 10:00 A.M. and 3:00 P.M., and 6/11/24 at 7:00 P.M.7/2/24 at 10:00 A.M. and 3:00 P.M., 7/3/24 at 3:00 P.M. , 7/6/24 at 10:00 A.M. and 10:00 A.M., and 7/8/24 at 3:00 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Treatments-Cleanse right posterior thigh with wound cleanser, pat dry, apply collagen, then cover with dry dressing was not documented as completed on 6/14/24, 6/16/24, and 6/18/24 all on day shift. House barrier cream to buttocks, coccyx, and peri-area every shift was not documented as applied on 6/18/24. A Physician's Progress Note dated 6/3/24, indicated Resident B had a stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle (defined by Center for Medicare & Medicaid Services), pressure injury to the right posterior wound to the thigh. During an interview, on 7/11/24 at 1010 A.M., with Resident B, he indicated he thought the nursing staff did not check his blood sugar levels like they should, but indicated he did not know for sure. 2. A record review was completed for Resident L on 7/11/24 at 1:38 P.M. Diagnosis included, but were not limited to, diabetes, altered mental status, history of stroke, peripheral vascular disease, depression, and anxiety. A Discharge MDS assessment, dated 6/5/24, indicated Resident L was severely cognitively impaired, was receiving insulin and antidepressants while a resident. The most recent active Physician's Orders included: -Accu Check 4 times daily before meals and at bedtime related to diabetes, ordered 5/1/24 with no end date. -Humalog Injection Solution 100 units/Ml (Insulin Lispro), per sliding scale, before meals and at bedtime. -Aspirin 81 oral tablet, 1 tablet by mouth daily related to peripheral vascular disease, ordered 5/1/24 with no end date. -Lexapro 10 mg tablet daily for depression, ordered 5/2/04 with no end date. -Metformin 500 mg tablet, 2 times daily related to diabetes, ordered 5/2/24 with no end date. -Nutritional Shake 2 times daily for weight loss give 237 ml 2 times daily, ordered 5/23/24 with no end date. Resident L's Medication and Treatment Records indicated, from 6/1/24 to 7/11/24, the resident did not receive the following as ordered: -Accucheck blood sugar checks on 6/7/24 at 5:00 P.M., 6/10/24 at 7:00 A.M., 11:00 A.M., 5:00 P.M., 6/20/24 at 7:00 A.M., 11:00 A.M., 5:00 P.M., and 6/21/24 at 7:00 A.M. and 11:00 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of South Bend	52654 N Ironwood Rd South Bend, IN 46635

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-Humalog Injection Solution 100 units/Ml (Insulin Lispro), per sliding scale, before meals and at bedtime on 6/7/24 at 5:00 P.M., 6/10/24 at 7:00 A.M., 11:00 A.M., and 5:00 P.M., 6/20/24 at 7:00 A.M., 11:00 A.M.and 5:00 P.M., and 6/21/24 at 7:00 A.M. and 11:00 A.M.

-Lexapro 10 mg on 6/10/24 at 9:00 A.M.

-Metformin 500 mg tablet on 6/10/24 at 7:00 A.M. Nutritional Shake on 6/10/24 at 10:00 A.M. and and 6/18/24 at 2:00 P.M.

3. A record review was completed for Resident K on 7/11/24 at 3:08 P.M. Diagnosis included, but were not limited to, bipolar disorder, congestive heart failure, chronic obstructive pulmonary disease, intermittent explosive disorder, schizocarp disorder, post traumatic stress disorder, renal failure, diabetes.

A Significant Change MDS assessment, dated 4/26/24, indicated Resident K was cognitively intact, received antipsychotic medication on a routine basis, and had received 7 days of insulin injections in the 7 day look back period.

The current Physician's Orders included:

-Accu Check 4 times daily before meals and at bedtime related to diabetes, ordered 3/28/24 with no end date.

-Insulin Lispro Injection Solution 100 units/Ml, inject per sliding scale before meals and at bedtime ordered 3/28/24 with no end date.

-Zofran 4 mg tablet, 1 tablet before meals for nausea, ordered 4/18/24.

-Cleanse stage 2 to coccyx with wound cleanser, pat dry, apply medi-honey and then bordered foam daily ordered 4/18/24 with no end date.

Resident K's Medication and Treatment Records indicated, from 6/1/24 to 7/11/24, the resident did not receive the following as ordered:

-Medication-Accucheck blood sugar checks on 6/5/24 at 7:00 A.M., 11:00 A.M., and 5:00 P.M., 6/7/24 at 7:00 A.M., 11:00 A.M., and 5:00 P.M., 7/1/24 at 7:00 A.M. and 11:00 A.M., 7/3/24 at 11:00 A.M., and 5::00 P.M., and 7/6/24 at 7:00 A.M., 11:00 A.M., and 5:00 P.M.

-Insulin Lisprol injection Solution 100 units/Ml, inject per sliding scale before meals and at bedtime on on 6/5/24 at 7:00 A.M., 11:00 A.M., 5:00 P.M., 6/7/24 at 7:00 A.M., 11:00 A.M., and 5:00 P.M., 7/1/24 at 7:00 A. M., 11:00 A.M., 7/3/24 at 11:00 A.M., 5:00 P.M., 7/6/24 at 7:00 A.M., 11:00 A.M., and 5:00 P.M.

-Zofran 4 mg tablet on 7/8/24.

-Treatment-Cleanse stage 2 to coccyx with wound cleanser, pat dry, apply medi-honey and then bordered foam daily on 6/16/24.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Majestic Care of South Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N Ironwood Rd South Bend, IN 46635	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 7/11/24 at 11:13 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to, necrotizing fasciitis (flesh eating disease) to a sacral wound, insulin dependent diabetes, End Stage Renal Disease (ESRD) requiring hemodialysis and a history of a cardiac arrest. A Care Plan, dated 3/18/24, indicated the resident was at risk for complications of hypoglycemia or hyperglycemia (low or high blood sugar) due to diagnoses of diabetes. The interventions included, but were not limited to, blood sugars as ordered and administer medication as ordered. A Care Plan, dated 3/19/24, indicated the resident was at risk for abnormal bleeding secondary to anticoagulant therapy. The interventions included but were not limited to; administer medications as ordered. A Physician's Order, dated 3/27/24, indicated the resident was to be administered Heparin (blood thinner) 5000 units/milliliter by subcutaneously every 12 hours for blood thinner. The Medication Administration Record (MAR) was blank indicating the Heparin was not administered as ordered on the following times and dates: -6/20/24 at 9:00 A.M. -6/21/24 at 9:00 A.M. A Physician's Order, dated 5/14/24, indicated the resident was to have her blood sugar tested via accu-check before meals and at bed. Then the resident was be administered Humulin N (insulin) per a sliding scale for her diabetes. The Medication Administration Record (MAR) was blank indicating the resident's blood sugar was not documented and insulin administered as ordered on the following times and dates: -6/14/24 at 5:00 P.M. -6/18/24 at 12:00 P.M. and 5:00 P.M. -6/20/24 at 8:00 A.M., 12:00 P.M. and 5:00 P.M. -6/21/24 at 12:00 P.M. On 7/11/24 at 10:42 A.M., the Administrator provided a policy titled, Medication Administration, dated 1/10/24, indicating it was the current facility policy. The policy indicated, .Medications are administered .as ordered by the physician and in accordance with professional standards of practice On 7/11/24 at 12:45 P.M., the Director of Nursing provided a policy titled, Wound Treatment Management, dated 1/1/24 indicating it was the current facility policy. The policy indicated, .Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Majestic Care of South Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N Ironwood Rd South Bend, IN 46635	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 1:06 P.M., the Administrator provided a policy titled, Pressure Injury Prevention and Management, dated 1/1/24, indicating it was the current facility policy. The policy indicated, .This facility is committed to the prevention of avoidable pressure injuries .and to provide treatment and services to heal the pressure ulcer/injury On 7/15/24 at 12:53 P.M., the Administrator provided a policy titled, Documentation of Medication Administration, dated April 2007, and indicated the policy was the one currently used by the facility. The policy indicated .A Nurse or Certified Aide (where applicable) shall document all medications to each resident on the resident's medication administration record (MAR) .3. Documentation must include, as a minimum .f. Signature and title of the person administering the medication This citation relates to Complaint IN00437316. 3.1-25(a) 3.1-25(b)(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31719 Based on observation and interview, the facility failed to ensure 1 of 3 shower rooms were cleansed after use. This had the potential to affect all 55 residents residing on the South unit, Finding includes: On 7/9/24 at 10:52 A.M., the following was observed in shower room A, on the South Unit: -An opened package of wipes on the sink. -Brief packages lying on top of a dresser/drawer. -A moderate size smear of a brown substance in front of toilet. -A smear of white substance on left assist bar, for the toilet. -Used towels on a cart. -A large chair with a wet sheet on it. -Trash in bags on floor near the door. During an observation of the South shower room A on 7/9/24 at 2:21 P.M., with Unit Manger the following was observed: -An opened package of wipes on the sink. -Brief packages lying on top of a dresser/drawer. - A moderate size smear of a brown substance in front of toilet. -A smear of white substance on left assist bar, for the toilet. -Used towels on a cart. -A large chair with a wet sheet on it. -Trash in bags on floor near the door. During an interview on 7/9/24 at 2:26 P.M., the Unit Manager indicated the staff person completing the showers should have picked up trash and linens and removed them from the area. and tthe housekeeping should have cleaned the floor, toilets and sink and the day shift staff had left for the day and their duties were not completed, as the shower room should not have been left as observed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at 4:09 P.M., the Housekeeping Manager indicated the housekeepers were to cleanse the shower room floor first thing in the morning before showers started. After that time, the CNAs were supposed to contact a housekeeper if the floors needed to be cleansed again. The CNAs were to pick up trash and linens after each shower. The Housekeeping Manager indicated there was no policy indicating who was responsible and when the shower rooms were to be cleansed. The Housekeeping Manager provided a South Hallway cleaning procedure, which indicated housekeeping staff were to clean common areas and offices such as shower rooms. On 7/9/24 at 3:36 P.M., the Administrator provided a policy titled, Routine Cleaning, dated 1/2/24 and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of the facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible This citation relates to Complaint IN00436698. 3.1-19(f)