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	08/23/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 31719 Based on interview and record review, the facility failed to ensure 3 of 3 residents reviewed for facility initiated transfers to a local hospital for dialysis treatments, received documentation including a statement of notification of the transfer, appeal rights, a copy of the bed hold policy and the Ombudsman's information. (Resident E, D and F) Findings include: 1. During an interview, on 8/19/24 at 1:05 P.M., Resident E's sister indicated Resident E was unable to breath, on 8/14/24, and had been transferred to a local emergency room (ER) where she required an immediate dialysis treatment. On 8/20/24 at 2:50 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to, End Stage Renal Disease (ESRD), dependence on renal dialysis, congestive heart failure and respiratory failure. Nursing Progress Notes were reviewed from 8/12/24 through 8/14/24 and there were no nursing assessments documented for Resident E, who had not received her regularly scheduled dialysis treatment, on Monday 8/12/24 or Tuesday 8/13/24. There were no Nursing Progress Notes indicating the resident had been transferred to a local hospital on 8/14/24, nor was there an order from a physician to transfer the resident to a local hospital's ER (emergency room). There was no documentation the facility had provided Resident E a copy of statement of the notification of her transfer, appeal rights, a copy of the bed hold policy and the Ombudsman's information An ER Physician Report, dated 8/14/24 at 11:36 A.M., indicated Resident E had complained of being short of breath and had not had dialysis since last Friday. Resident E was admitted to the hospital in guarded condition. 2. On 8/21/24 at 3:15 P.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses included, but were not limited to: ESRD, dependence on renal dialysis, diabetes and hypertension. (continued on next page)

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note, dated 8/12/24 at 11:00 A.M., indicated the resident was noted to have shortness of breath and an overall decline. The Nurse Practitioner was notified regarding the resident's change of condition and an order was received to send the resident to a local ER. Emergency Medical Staff (EMS) arrived and resident was transported to the ER via an ambulance. There was no documentation the facility had provided Resident F a copy of statement of the notification of her transfer, appeal rights, a copy of the bed hold policy and the Ombudsman's information An emergency room Admission Note from the Physician on 8/14/2024, indicated Resident D was admitted to the hospital on 8/14/2024 due to not receiving hemodialysis. 3. Resident D's record review was completed 8/21/2024 at 11:48 A.M. His diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, heart failure, anemia, depression, hemiplegia and hemiparesis. A Nursing Progress Note, dated 8/14/2024 at 4:34 A.M., indicated Resident D returned from hospital because the hospital did not administer dialysis treatments at night and the resident should return in the morning for dialysis. A Nursing Progress Note, dated 8/15/2024 at 5:40 A.M., indicated the resident was sent to the hospital for dialysis. There was no order, from the Physician, to send the resident to the hospital on 8/13/24 nor 8/14/24. There was no documentation the facility had provided Resident D a copy of statement of the notification of her transfer, appeal rights, a copy of the bed hold policy and the Ombudsman's information During an interview on 8/22/24 at 1:10 P.M., the Unit Manager LPN 12 indicated she was the one who had sent out Resident E and Resident D, on 8/14/24, due to them not having the required dialysis and no set place or time set up to receive dialysis. She indicated she did not have the required transfer forms completed for the resident's transfers to a local hospital, this included Resident E, Resident F and Resident D. On 8/23/24 at 10:47 A.M., the Regional Nurse Consultant confirmed there were no transfer documentation notes and/or forms, for Resident E, Resident F nor Resident D. On 8/22/24 at 10:24 A.M., the Interim Administrator provided a policy titled, Transfer and Discharge (including AMA), dated 1/1/24, and indicated the policy was the one currently used by the facility. The policy indicated .4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman . 12. Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified): a. Obtain physician's orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis . d. The original copies of the transfer form and Advance Directive accompany the resident. Copies are obtained in the medical record . g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated This citation relates to Complaints IN00441005 and IN00441105. 3.1-12(a)(6)

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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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31719 Based on interview and record review, the facility failed to ensure residents who required dialysis services continued to receive those services in accordance with physician orders when the facility-based dialysis center closed on 8/12/2024 for 6 of 7 residents reviewed for dialysis services. (Resident D, E, F, R, S and V) This deficient practice resulted in Resident D and Resident E missing two dialysis treatments and required transfer to an acute care hospital for treatment of critical laboratory results and emergency dialysis treatments. The Immediate Jeopardy began on 8/12/24, when the facility failed to ensure the provision of dialysis services were continued for the residents who previously had an order for Dialysis on Monday-Friday until the facility-based dialysis unit closed on Friday, 8/10/24, without residents having arrangements in place for when their next dialysis treatment would occur, on Monday 8/12/2024. The Interim Administrator, Interim Director of Nursing and the Regional Nurse Consultant were notified of the Immediate Jeopardy (IJ) on 8/22/24 at 1:40 P.M. Findings include: The former in-house dialysis clinic provided a letter, sent to the facility and addressed to the previous Administrator, on 4/25/24, which indicated they were requesting repairs, due to the (Indiana) Department of Health (IDOH) had surveyed the den in May of 2023 and noted several deficiencies. The letter indicated, since the survey, the dialysis staff had asked former and current Administrators to make repairs via email, meetings and in-person conversations, but to date, the repairs had not been made. The letter indicated a failure to repair would result in termination of the in-house dialysis agreement due to unsafe conditions/violations deemed by the (I)DOH. A letter, dated 6/10/24, provided by the former in-house dialysis provider, indicated .effective July 10, 2024 (the Termination Date) due to breach of agreement for failure to make repairs in accordance with provision 21.C in the Long-Term Care Facility Renal Dialysis Affiliation Agreement. For clarification purposes, Wednesday, July 10, 2024, will be the final day [name of dialysis company] provides renal dialysis services at the SNF [Skilled Nursing Facility] An email notification, from the former dialysis in-house clinic/den, dated 7/5/24, indicated .We have extended our services by 30 days to help give you all more time to place the dialysis patients to outpatient clinics. Our new date we will be ceasing operation is August 9th During an interview, on 8/20/24 at 12:47 P.M., an emergency room (ER) Manager, from the local hospital, indicated Residents E and Resident D were both sent to theER on [DATE]. They both required emergency dialysis treatment, while in the ER and were then admitted to the hospital. The hospital's concern was that the residents were not provided dialysis services at the facility and/or set up with dialysis times according to those residents after the in-house dialysis services ceased. ER Manager indicated Resident F, also from the facility, had been transported to theER on [DATE], due to not having dialysis and was discharged from the hospital on 8/16/24. (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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview, on 8/19/24 at 1:05 P.M., Resident E's sister indicated Resident E was still at the hospital because the facility did not make arrangements for her to have dialysis when they knew the in-house dialysis was closing. She indicated the facility knew for 2 months they were going to close the unit. Resident E had her last had her last in-house dialysis on Friday the 9th. On Monday (8/12), she contacted the facility to find out when Resident E's next dialysis would be or where her sister would be going for dialysis, and they only told her not to worry. On 8/13/24, she was told her sister would be going somewhere in (neighboring city) to have her dialysis three times a week, however the facility would not be able to transport her. Then the facility said they would try a facility in [2 larger cities which were 2-3 hours away] to see if they would accept Resident E. On Wednesday (8/14), her sister indicated she was able to breath and was being sent to a local ER, where she required immediate dialysis and blood transfusion. 1. On 8/20/24 at 2:50 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: End Stage Renal Disease (ESRD), dependence on renal dialysis, congestive heart failure and respiratory failure. A Physician Order, dated 3/28/24, indicated, .Hemo-Dialysis 5 [five] times a week (Mondays, Tuesdays, Wednesdays Thursdays, Fridays). In house An Annual Minimum Data Set (MDS) assessment, dated 5/22/24, indicated the resident was alert and oriented, had no cognitive deficits, required dialysis and used oxygen. A current Care Plan, initiated on 5/25/23, and revised 6/2/24, indicated resident required Hemodialysis (in house) related to End Stage Renal Disease. The intervention included but were not limited to: .Dialysis Days: Mondays, Tuesdays, Wednesdays, Thursdays, Fridays . observe for signs of worsening renal insufficiency such as changes in level of consciousness .changes in heart and lung sounds .observe for symptoms of fluid volume excess such as edema, shortness of breath, crackles in lungs, weight gain or hypertension (sic) A current Care Plan, initiated on 5/25/23, and revised on 3/12/24, indicated the resident was at risk for fluid imbalance due to kidney failure, with refusal of dialysis or stopping dialysis early. The interventions included but were not limited to: .observe for signs of fluid overload: Anorexia, Anxiety, Mood/behavioral changes, Confusion, Edema, Nausea/vomiting, Shortness of breath, difficulty breathing (Dyspnea), Increased respirations (Tachypnea), Difficulty breathing when lying flat (Orthopnea), Congestion, Cough, Fatigue, Jugular Venous Distention (JVD), Sudden weight gain. Document and notify MD [Medical Doctor] of abnormal findings (sic) A electronic mail (email) communication , dated 8/12/24, between the previous Administrator and the Regional Director of Operations was provided, on 8/22/24, by the current Administrator. The email indicated chair times for Resident E were written on the email, but did not indicate at what facility she was to have her dialysis treatments. The nursing progress notes, dated 8/12/24 through 8/14/24, did not include documentation to indicate Resident E missed dialysis treatments, staff effectively assessed or monitored for fluid volume overload or for complications of not receiving dialysis in accordance with the physician's order. The notes did not include documentation to indicate staff attempted to secure dialysis services on 8/12/24 or 8/13/24 or to indicate the resident experienced a significant change in condition and was transferred to the hospital. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility Dialysis Post Communication Record for Resident E, dated 8/14/24 at 4:18 A.M., indicated the resident was admitted to the hospital from dialysis. Addition information indicated .sent to [name of hospital] for abnormal labs (potassium hemoglobin) There were no lab documentation in the chart and Regional Nurse Consultant confirmed there were no lab draws for the resident from 8/12-8/14/24 and she did not know why the nurse completed a PostDialysis Communication Record for Resident E when there was no dialysis center and chair time set up for the resident for 8/14/2024. The next consecutive nursing progress note, dated 8/14/24 at 11:40 A.M., indicated the resident was away from the facility receiving dialysis. There were no nursing progress notes, dated 8/14/24 regarding transfer or discharge forms having been completed for Resident E. An ER Physician Report, dated 8/14/24 at 11:36 A.M., indicated Resident E complained of being short of breath and had missed two dialysis treatments since the previous Friday. Resident E told the physician she typically received dialysis Monday through Friday, however the nursing home where she resided was only able to provide dialysis until Friday (8/9) and she had not received dialysis since 8/12/24. Resident E reported the previous in-house dialysis service stopped and the facility did not ensure she continued receiving dialysis services. The report indicated Resident E suffered from fluid overload from lack of dialysis related to resident not receiving dialysis for five days. She was admitted to the hospital in guarded condition. Lab work at the hospital indicated critical levels of Potassium at 6.5, Creatinine at 10.4 [no normal ranges were provided] and hemoglobin at 6.4 with BUN (Blood Urea Nitrogen level) high at 83. The patient received a blood transfusion of one unit of packed red blood cells due to hemoglobin being less than 7. Hemoglobin is a value assigned to the number of red blood cells that carry oxygen. During an interview, on 8/19/2024 at 1:05 P.M., Resident E's sister indicated Resident E was still at the hospital because the facility did not make arrangements for her to have dialysis when they knew the in-house dialysis center was closing. She indicated the facility knew for two months they were going to close the in-house dialysis unit. Resident E has her last in-house dialysis treatment on 8/9/24. On Monday, 8/12/24, the family member indicated she contacted the facility to find out when Resident E's next dialysis would be or where her sister would be going for dialysis and the facility staff only told her not to worry. On 8/13/24, she was told her sister would be going somewhere in [neighboring city] to have her dialysis three times a week, however, the facility was not able to transport her. The the facility said they would try a facility in [two larger cities which were two - three hours away] to see if they would accept Resident E. On Wednesday (8/14/24) her sister indicated she was not able to breathe and was being sent to a local ER because she required immediate dialysis and a blood transfusion. During an interview, on 8/20/24 at 2:45 P.M., the interim Administrator indicated there were no dialysis centers within a forty-five mile radius, around the facility, that would accept Resident E. The only options suggested to her, were to have her transferred to a facility in [2 larger cities which were 2-3 hours away]. The interim Administrator indicated no documentation could be provided to indicate dialysis services had been secured for Resident E on 8/12/24, 8/13/24 and 8/14/2024. The resident required emergent transfer to the hospital on 8/14/24 (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/21/24 at 10:15 A.M., Resident E indicated she had been in the hospital since last Wednesday (8/14/24) and her last day of dialysis, at the facility, was on 8/9/24. On the last day of her dialysis treatment, at the facility, the previous Administrator had told the resident the facility would have dialysis setup for her, by Monday 8/12/24. The Transportation person, Employee 7, had also told the resident the facility was going to make sure she received her dialysis treatment on Monday 8/12/24. On Monday 8/12/24, the resident indicated she did not receive her dialysis treatment and was told by the Interim Administrator they could not find anywhere to send her because she required a Hoyer lift for transport needs. The facility told her she could look for my own dialysis center, which made her angry and she was ready to give up. Resident E indicated she had never received any kind of nursing assessment on Saturday (8/10) through Wednesday (8/14). The resident indicated a nurse had listened to her lungs, on Wednesday, after she complained about not being able to breath and then the nurse decided to send her to the hospital. Resident E indicated she was admitted into the hospital because she needed dialysis. The resident was upset because she was then told she could not go back to the facility because she needed dialysis and the facility would not provide her transportation to a dialysis clinic, because she needed a Hoyer lift for transfers. However, the resident indicated she did not need a Hoyer lift for transfers and the resident indicated the Physical Therapist at the hospital also confirmed she did not require a Hoyer lift for transfer needs. During an interview, on 8/21/24 at 11:32 A.M., Transport Employee 7 indicated she had sent referrals [to local dialysis centers] for all dialysis residents approximately a month ago, prior to the in-facility dialysis center's closure date. However, the previous Administrator had informed Employee 7 she would be working on the referrals, so Employee 7 had no further involvement with the referrals. On Monday 8/12/24, the former Administrator was released from her duties at the facility and Transport Employee 7 was notified that day to start making transportation arrangements for all the residents in the building requiring dialysis. Resident D was referred to [2 different facilities over 1.5 hours away],a facility, both with in-house dialysis. It was Employee 7's understanding the facility would be providing transportation to one of these facilities. Resident E was scheduled to have dialysis on Monday, Wednesday and Friday at a local dialysis center and was scheduled to have her first dialysis treatment there on Wednesday 8/14/2024, however the dialysis center had called on Tuesday, 8/13/24, and informed Employee 7 they could not take Resident E due to her weight and there was no other treatments scheduled for Resident E. Employee 7 indicated no residents had started their dialysis treatments on Monday 8/12/24. Although Employee 7 indicated Resident E was scheduled to receive dialysis treatments 3 times a week, on Monday, Wednesday and Friday at a dialysis center for treatments, there was no physician's order provided to change Resident E's dialysis treatments from a 5 day Monday- Friday schedule to a 3x a week - Monday, Wednesday and Friday schedule. There was no documentation provided regarding to whom Employee 7 had communicated the issues with Resident E's dialysis treatments. During an interview, on 8/21/24 at 3:50 P.M., with alert and oriented Resident K indicated she had been roommates with Resident E for some time. Resident K indicated on Wednesday (8/14/24), last week, both her and Resident E were in the activity room when a staff member came in the room and told Resident E she was going to the ER. Resident K indicated Resident E kept telling her she did not feel well and was worried about not receiving her dialysis treatments due to transportation concerns. Nursing Progress Note for Resident E, dated 8/14/24 at 11:40 A.M., indicated LOA (Leave of Absence) at dialysis. There were no Nursing Notes indicating the resident had been transferred to a local hospital. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview, on 8/22/24 at 1:02 P.M., LPN 13 indicated he had written the Progress Note, dated 8/14/24 at 11:40 A.M He indicated he thought Resident E was at an outside dialysis center and when he heard she was in the hospital he assumed she went there from the dialysis center. He was not aware of when or where Resident E's dialysis days at an outside dialysis center had been scheduled. During a interview, on 8/23/24 at 1:33 P.M., an Admission Coordinator (AC) for (multiple local dialysis centers) indicated the facility had contacted and started the admission process for Resident E was receive from the facility, on 7/19/2024. The AC indicated no documentation could be provided to determine dialysis services were scheduled on 8/12/24. In addition, the AC indicated she had never communicated to the facility the need for a bariatric chair for Resident E. The AC indicated no documentation could be provided to indicate communication with the facility occurred between 7/19/24 - 8/19/24 when a second request for dialysis services was received. 2. On 8/21/24 at 3:15 P.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses included, but were not limited to: ESRD ,dependence on renal dialysis, diabetes and hypertension A Quarterly Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was cognitively intact and required dialysis treatments. A current Care Plan, initiated on 3/6/23 and revised on 1/17/24 indicated the resident required Dialysis related to ESRD. The interventions included, but were not limited to: .observe for symptoms of fluid volume excess such as edema, shortness of breath, crackles in lungs, weight gain or hypertension (sic) A current Care Plan, initiated on 3/23/24 and revised 1/17/24, indicated the resident was at risk for fluid imbalance due to ESRD. The interventions included, but were not limited to: .observe for signs of fluid overload: Anorexia, Anxiety, Mood/behavior changes, Confusion, Edema, Nausea/vomiting, Shortness of breath, difficulty breathing (Dyspnea), Increased respirations (Tachypnea), Difficulty breathing when lying flat (Orthopnea), Congestion, Cough, Fatigue, Jugular Venous Distention (JVD), Sudden weight gain. Document and notify MD of abnormal finding (sic) A Physician Order for Resident F, dated 3/27/24, indicated .Hemo-Dialysis five times a week (Mondays, Tuesdays, Wednesdays Thursdays, Fridays). In- house A electronic mail (email) communication , dated 8/12/24, between the previous Administrator and the Regional Director of Operations was provided, on 8/22/24, by the current Administrator. The email indicated chair times for Resident F were written on the email, but did not indicate at what facility he was to have his dialysis treatments A Nursing Progress Note, dated 8/12/24 at 11:00 A.M., indicated the resident was noted to have shortness of breath and an overall decline. The Nurse Practitioner was notified regarding the resident's change of condition and an order was received to send the resident to a local ER. Emergency Medical Staff (EMS) arrived and resident was transported to the ER via an ambulance. It was unclear why the nursing progress note, dated 8/12/24 for Resident F was not completed until 11:00 A.M., after he had been evaluated in the local ER. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A un-timed Nurse Practioner (NP) Acute Note, dated 8/12/24, indicated Resident F was short of breath, had a cough, was drowsy and had labored respirations. The note indicated the resident, initially refused to be transferred to the hospital for evaluation of fluid volume overload and dialysis treatment, but then agreed. An ER Physician Report, dated 8/12/24 at 10:45 A.M., indicated Resident F had a medical history of ESRD, on dialysis with last dialysis on Friday (8/9/24) who presented to the Emergency Department with shortness of breath, some congestion, a cough and altered mental status. He was admitted to the hospital's Intensive Care Unit (ICU), in guarded condition with a nephrology consult. Lab work completed in the ER for Resident F included, but was not limited to: high potassium level at 5.4, high BUN at 76 with a critical Creatinine level at 9.42. A Physician's Order, dated 8/13/24, indicated .Dialysis M/W/F @ 11:45 AM [name and address of dialysis center]. Please have ready for transport @10:45 am, one time a day every, Mon, Wed, Fri The order was received while the resident was hospitalized . The resident was discharged from the hospital on 8/16/2024 and returned to the facility. The Physician's order changing the resident's dialysis treatments to three times a week was not received for Resident F until 8/13/24. During an interview on 8/21/24 at 11:47 A.M., Transport Employee 7 indicated Resident F had a medical issue and was sent the hospital. Transport Employee indicated Resident F had an appointment set up for dialysis treatments for Monday (8/12/24) at 11:50 A.M., at the dialysis center, but was sent to the hospital and was admitted on [DATE] prior to the 11:50 A.M. appointment. During an interview, on 8/22/24 at 10:43 A.M., Resident F indicated he was told about the in-house dialysis closure by an aide who worked for the company who provided his dialysis. He indicated arrangements for his dialysis was never done until after the closure. He indicated he went to the hospital on Monday, 8/12/24, and received dialysis while there, but he had no information, prior to his admission to the hospital, regarding an outside dialysis center nor when he would next go to dialysis. After his return from the hospital, he indicated he was informed he would be going to a dialysis center on Mondays, Wednesdays and Fridays for treatments. During an interview, on 8/22/24 at 1:54 P.M., the facility NP indicated the in-house dialysis center had not given the facility much of a notice, maybe two-four weeks prior to their closure. She indicated she had rounded on all the dialysis resident's due to problems with the facility setting up dialysis for those residents requiring dialysis, and would be missing their Monday dialysis. She had instructed Nurse Manager 12 to send residents to a local ER if they had no had dialysis by Wednesday the 14th. She indicated she was contacted about Resident F having some concerns which may or may not have been related to him not having dialysis on his regular scheduled Monday, and had ordered the nurses to send him to theER on [DATE]. There was no documentation provided the NP had notified her supervising MD of the issues regarding missed and/or unscheduled dialysis treatments per orders. During an interview with the Admissions Coordinator (AC) for multiple, local dialysis clinics, on 8/23/2024 at 1:39 P.M. she indicated Resident F had an initial request for dialysis made on 7/19/2024 however, there was no chair time set up for him until after he was hospitalized . His first dialysis treatment at the center was on 8/19/24. (continued on next page)

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	155219	A. Building B. Wing	08/23/2024

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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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Resident D's record review was completed 8/21/2024 at 11:48 A.M. His diagnoses included, but were not limited to: end stage renal disease, dependence on renal dialysis, heart failure, anemia, depression, hemiplegia and hemiparesis. A Physician's order, dated 3/27/2024, indicated Resident D should receive in house dialysis 5 times a week on Monday, Tuesday, Wednesday, Thursday and Friday. A current Care Plan for Resident D, with a revision date of, 4/29/2024, indicated the resident required hemodialysis and at times may refuse dialysis. The goal for the Care Plan was to remain free of complications related to dialysis. Interventions to the Care Plan included, but were not limited to: - Dialysis Days: Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays revised on 4/29/2024. - Observe for symptoms of fluid volume deficit such as hypotension, postural changes in blood pressure, dizziness, thirst, dry oral mucosa, weight loss, nausea or muscle cramps 1/13/2022 - At times, resident will refuse dialysis. Staff to re-approach as needed. If resident continues to refuse, staff to offer education on importance of receiving dialysis as well as inform resident of potential adverse effects. (sic) A Social Services Note, dated 7/30/2024, indicated the Social Service Director had called Facility B, and left a voicemail inquiring about a fax number or email to send a referral for a resident transfer to be closer to his family and other potential dialysis centers. A Quarterly Minimum Data Set (MDS) assessment, dated, 8/1/2024, indicated Resident D had intact cognition, had received dialysis while at the facility and had not rejected any care during the previous seven days. A Social Services Note, dated 8/7/2024, indicated the interim Social Service Employee had sent a referral for Resident D to Facility B and was awaiting acceptance or denial. A Dialysis Hand Off Communication Report, dated 8/9/24, indicated resident had refused treatment from the in-house dialysis, provided at the facility. There was no documentation indicating Resident D had been dialyzed after 8/8/2024. An electronic mail (email) communication, dated 8/12/24, between the the previous Administrator and the Regional Director of Operations, was provided on 8/22/24 by the current Administrator. The email did not include documentation to indicated dialysis services were scheduled for Resident D on 8/12/24. An Acute Note from the Nurse Practitioner, dated 8/12/2024, indicated Resident D had outpatient hemodialysis arranged, and it was ok to wait another day for his outpatient dialysis A Nursing Progress Note, dated 8/14/2024 at 4:34 A.M., indicated Resident D returned from hospital because the hospital could not administer dialysis treatments at night and the resident was to return in the morning for dialysis. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Nursing Progress Note, dated 8/15/2024 at 5:40 A.M., indicated the resident was sent to the hospital for dialysis but was then admitted for pneumonia. An emergency room Admission Note from the Physician on 8/14/2024, indicated Resident D was admitted to the hospital on 8/14/2024 due to not receiving hemodialysis and having the following critical lab levels: -Blood Urea Nitrogen (BUN) 104 mg/dL (normal levels are 6-25 mg/dL) -Creatinine 21.5 mg/dL (normal levels are 0.6-1.5 mg/dL) -Potassium 6.5 mmol/L (normal levels are 3.5-5.2 mmol/L) Resident D's record lacked documentation the Physician had been notified about Resident D not having outpatient dialysis arranged for any future treatments and/or had missed any dialysis treatments. During an interview, on 8/21/24 at 11:32 A.M., Transport Employee 7 indicated Resident D was referred to (2 different facilities over 1.5 hours away) ,a facility, both with in-house dialysis clinics. It was her understanding the facility would be providing transportation to one of these facilities once the resident had been accepted for admission. She indicated no residents were scheduled to start their dialysis treatments on Monday 8/12/24. During an interview on 8/21/24 at 1:45 P.M., Resident D indicated he was sent to the ER because he had not received dialysis since 8/9/24. Resident D had critical BUN, Creatinine and Potassium levels and needed to be dialyzed immediately. The first day he went to the ER for dialysis was on 8/13/2024 and staff had only informed him he needed dialysis; they never told him he was being sent to the ER. The resident indicated he was not assessed on any day since his last dialysis treatment. He was notified at least 30 days in advance of the facility no longer offering dialysis in the facility. He believed the staff was looking for a new place for him to live and were setting up dialysis. Resident D was never made aware by any staff member that the facility was having a hard time finding somewhere for him to go. [name of skilled facility 1.5 hours away], contacted Resident D to inform him he was accepted but needed some papers from the facility. He had told the new Administrator, and she said she would take care of it. During an interview on 8/21/24 at 11:50 AM, an Admission Director (AD) for Facility A indicated an admission referral for Resident D was received, the resident was approved for admission, and more information was requested from the previous Administrator for consideration to be admitted into the hemodialysis program on 8/12/24. The AD for Facility A indicated a response was not received even though her staff had made attempts to contact the resident's residing facility on 8/13/24 and 8/14/24, for additional information. During an interview on 8/21/2024 at 1:45 P.M., Admissions Director (AD) for Facility B (skilled facility approximately 2 hours away) indicated they had not received a referral for Resident D prior to 8/15/24. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/22/2024 10:35 A.M., the Business Office Manager indicated Facility A had called on 8/13/2024 and had inquired about family members' contact information for Resident D. Facility A called again on 8/14/2024 and requested clinical information and the call was transferred to the north nursing unit. During an interview, on 8/22/2024 at 11:23 A.M., QMA 3 indicated Resident D's face was swollen so he was sent out for dialysis because he had not been set up for outpatient dialysis treatments and had not been to dialysis. QMA 3 called a non-emergency transport for both him and Resident B and both residents were sent to the hospital for dialysis. During an interview on 8/22/2024 at 11:25 A.M., the Regional Nurse Consult indicated there was not any transfer or discharge paperwork completed for Resident D on 8/13 or 8/14/2024 when the resident was sent to the hospital for dialysis. During an interview on 8/22/2024 at 12:46 P.M., the Unit Manager indicated Resident D did not have outpatient dialysis setup to start on the week 8/12/2024. On 8/9/2024., the previous Administrator sent her a text message notifying her any resident who did not have a new dialysis center setup should be sent to the hospital on their next dialysis day. The Medical Director and Nurse Practitioner were told all residents had outpatient dialysis setup, but they did not. On 8/13/2024, when the Unit Manager returned to work after being off for 3 days, the Unit Manager was notified Resident D was not looking well. The UM indicated Resident D's face was swollen and it sounded like he had fluid on his lungs. The Nurse Practitioner was notified and gave an order to send Resident D to the hospital. Resident D has never refused dialysis, and she had never been notified he had refused his dialysis treatment. All refusals for any treatment should be documented in the chart and the provider notification of refusal should also be documented. She was not able to provide any notes of why the resident was sent to the hospital in August. On 8/22/2024 at 1:45 P.M., the Regional Nurse Consultant provided a Dialysis Pre/Post Communication Record. The record indicated the resident had refused dialysis on 8/12/2024 at 4:36 A.M. and the Nurse Practitioner was notified. It was unclear why the form indicated the resident had refused a dialysis treatment on 8/12/2024 at 4:36 A.M. when there was no dialysis chair time or appointment set up for the resident on 8/12/2024. During an interview on 8/22/24 at 2:00 P.M., the Nurse Practitioner (NP) indicated Resident D did not have an appointment for dialysis on 8/12/24 because the facility requested she see Resident D due to not having a dialysis appointment on 8/12/24. The facility staff did not contact the NP on 8/9/24 notifying her Resident D refused dialysis. When the NP saw Resident D on 8/12/2024, she told the resident he could miss one more day of dialysis and the resident had no concerns or questions for the NP. During an interview with the Administrator, on 8/22/2024 at 2:12 P.M, from Facility B she denied ever receiving a voicemail referral inquiry or a faxed referral for Resident D from the facility. She indicated she received a referral inquiry for Resident D on 8/15/2024 but was uncertain if the inquiry was from the facility or the hospital During a interview, on 8/23/24 at 1:39 P.M., an Admission Coordinator (AC) for the (multiple local dialysis centers) indicated the facility had contacted had a request for Resident D but it was deleted and another request for services came in on 8/22/24. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. A record review for Resident R was completed, on 8/23/2024 at 11:12 A.M. Diagnoses included but were not limited to end stage renal disease, type 2 diabetes mellitus with neuropathy, and anemia in chronic kidney disease. A Physician Order,dated 3/28/24, indicated .Hemo-Dialysis 5 times a week (Mondays, Tuesdays, Wednesdays Thursdays, Fridays). In house A current Care Plan problem , initiated on 9/12/2022, indicated Resident R required hemodialysis. Interventions included, but were not limited to, -Dialysis days were Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays. -Observe for fluid volume excess such as edema, shortness of breath, crackles in lungs, weight gain or hypertension. (sic) A Nursing Progress Note, dated 8/12/24 at 8:53 A.M., indicated the resident would not receive dialysis services in accordance with physician orders, on 8/12/24, but dialysis services would resume on 8/13/24. There were no nursing notes and/or assessments from 8 [TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44111 Based on observation, interview and record review, the facility failed to ensure a Licensed Nurse followed standards of practice, during a medication administration, related to observation of mediation consumption for 1 of 1 residents observed during a random observation. (Resident Q) Finding includes: During a random observation and interview, on 8/20/2024 at 11:25 A.M., Resident Q had a breakfast tray and a small clear cup of containing multiple medications on his bedside table, approximately five feet from his bed. He indicated he did not know the medications were on the table and stated it was not unusual for them to be left in the room. Resident Q indicated his medications often ended up on the floor because it was not communicated to him that his medications had been left on the bedside table. On 8/20/24 at 11:39 A.M., LPN 11, an agency staffing nurse, summoned to Resident Q's room to verify the cup of medications observed were Resident Q's medications. LPN 11 indicated the medications were Resident Q's medications and asked had asked the resident if he was ready to take them, and the resident indicated he wanted to wait. LPN then removed the medications from the resident's room. During an interview, on 8/20/24 at 11:55 A.M., LPN 11 indicated Resident Q was alert and oriented so when he refused to immediately consume him medications, she left them in his room, on the bedside table and informed him of their location. She thought it was acceptable to do leave the medications in the room, unattended. She indicated the following medications were in the cup she had left at the bedside: Morphine Sulfate 30 milligrams (mg), Cetirizine 10 mg, Ondansetron 4mg, Sertraline 150 mg, Aspirin 81 mg, Plavix 75 mg , Divporex 250 mg, Gabapentin 300 mg, thera-M, Escitalopram 5 mg, Docusate 100 mg, Quetiapine 200 mg, and Tamsulosin 0.4 mg. On 8/21/2024 at 12:04 P.M., the Interim Director of Nursing provided a policy titled, Oral Medication Administration, dated 5/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated . Licensed nurse/authorized personnel must observe the resident swallow/ingest all medication(s) . 3.1-14