STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Fort Wayne	7519 Winchester Rd Fort Wayne, IN 46819

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44531 Based on interview and record review, the facility failed to ensure safe medication administration was completed resulting in medication error for 1 of 3 residents reviewed. (Resident E) Finding includes: A self-reported incident, submitted to Indiana State department of health, Resident E was given a dose of the medication Clozaril 150 milligrams (mg) during day shift. Shortly after, on second shift a second dose of 150 mg was given. On 6/21/24 at 9:41 AM, Resident E's record was reviewed. Diagnoses included, bipolar disorder, current episode manic without psychotic features, moderate. Chronic Obstructive Pulmonary disease. A review of physician orders indicated the following: Clozapine oral tablet (clozapine): give 150 mg by mouth one time only related to bipolar disorder unspecified. Order date: 6/5/24. Start date 6/5/24. End date 6/6/24. Clozaril oral tablet 100 mg (clozapine): give 1 table by mouth two times a day related to schizoaffective disorder; bipolar disorder unspecified current episode manic without psychotic features. Give with 50 mg to = 150mg. Order date: 6/3/24. Start date: 6/4/24. Clozaril oral tablet 50 mg (clozapine): give 1 table by mouth two times a day related to schizoaffective disorder; bipolar disorder unspecified current episode manic without psychotic features. Give with 100 mg to = 150mg. Order date: 6/3/24. Start date: 6/4/24. A review of progress notes indicated: Dated 6/3/24 at 2:11 PM: Call placed to physician regarding Resident E's continued behaviors. Update physician on Resident E's lab levels, physician indicated no changes in those orders. The physician gave the following orders for behaviors 1). Start Clozaril 150 mg twice a day. 2). Weekly Complete Blood Count (CBC). 3). Discontinue Risperdal. (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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 6/10/24 3:39 AM by Nurse Practitioner: On Wednesday June 5, 2024, facility requested an update on the status of the Clozaril registry. Confirmed it had been registered for Resident E that morning. The DON was notified. Later in the day, a call was placed by the DON to the office. The writer called back, was informed that Resident E had been dosed twice with 150 mg of Clozaril and was very sleepy. Writer advised they would inform the physician, which was done. The physician agreed that Resident 6 should have vitals signs monitor every 1-2 hours for 8 hours. DON was notified, order given to monitor vitals every 1-2 hours and to call with any other concerns or questions. In an interview on 6/21/24 at 11:33 AM Licensed Practical Nurse 5 (LPN) indicated she was asked by a QMA trainee, when the order was yellow in the medication record administration (MAR), is she to give the medication to Resident E. LPN 5 indicated to the trainee the medication was to be given. In an interview on 6/21/24 at 11:43 AM Qualified Medication Aide 4 (QMA) indicated they had been waiting for the medication (Clozaril) for a couple of days for Resident E. Pharmacy dropped it off, QMA 4 asked if she was to give the medication, the nurse indicated they would ask the DON. The DON indicated to give it, put in a one-time only order and give it. The nurse was putting the order in and QMA 4 gave the medication. When she went back to sign it out, it would not allow her to. She checked it several times but could not sign it out. During that time, she was asked if she could train another QMA. This QMA told her they were experienced, so QMA 4 agreed. QMA 4 indicated they were leaving on break, but advised the trainee not to give any medications. There were some treatments to be done, but they would start when QMA 4 returned. On the way back from break, QMA 4 received a text message from the DON asking if Resident E received the dose of Clozaril 150 mg. QMA 4 indicated the resident had recevied the medication. QMA 4 indicated it wasn't that long between receiving and when she was told Resident E received a second dose of Clozaril 150 mg. IN an interview on 6/21/24 at 12:19 PM the DON indicated the nurse was supposed to put a one time only entry for the medication of Clozaril 150 mg for Resident E, and it was to be given right away. She was not sure why it was not signed out by QMA 4. The text message was sent to QMA 4, to ask about the early dose of medication because it was yellow in the computer, but they gave Resident E the dose due to him having a behavior. Then they found out that they did give the earlier dose. The DON indicated, the physician was called, they noticed Resident E was becoming sleepier. The physician indicated the adverse reactions were lethargic and drowsiness, to monitor vitals every 1-2 hours. The DON indicated they are not sure why the medication didn't show up for QMA 4 to sign out. But after this error, they did an audit/plan of action of the whole building to make sure that physician orders are getting entered, and medications are being given correctly. A review of the facility's plan of action dated 6/5/24: Deficiency: Resident E received a second dose of the medication due to the first dose not being signed out. GOAL: All residents will receive correct medication dosage. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Actions to be taken . Nursing staff in-service on safe medication administration, including signing out of the EMAR, immediately after administering a medication . Statements obtained from nursing staff involved . All resident's MAR were reviewed for last 30 days for any missed documentation noted. Resident chart reviewed for accuracy of documentation . Audits to be completed each business day of the new order review/holes in MAR time 6 months and will evaluate in Quality Assurance and adjust accordingly . Interivews with staff indicated they had received reeducation regarding medication administration and signing out medications. Audits were visualized as having begun. A review of the current facility polices was provided by the Nurse Regional consultant on 6/11/24 at 9:48 AM: A policy, Administering medications, date 4/2019. The policy indicated . Medications are administered in a safe and timely manner, and as prescribed A policy, Charting and Documentation, dated 7/2017. The policy indicated . the following information is to be documented in the resident medical record .Medication administered A policy, Medication Error, dated 7/2020. The policy indicated .to ensure residents remain free from medication errors This citation is related to Complaint IN00436120. 3.1-48(b)