STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Jefferson Pointe	5700 Wilkie Dr Fort Wayne, IN 46804

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure a resident was adequately assessed and provider orders were followed after a change in condition for 1 of 3 residents reviewed. The facility failed to ensure bowel assessments were performed and an abdominal X-ray was completed as ordered. This resulted in the facility sending the resident to the hospital with a perforated bowel (Resident C).The Immediate Jeopardy began on 5/15/26 when the facility failed to assess Resident C's change of condition and complete an order for a follow-up x-ray. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on May 19, 2026, at 4:12 P.M. The immediate jeopardy was removed on 5/20/26 but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include: On 5/18/26 at 9:50 A.M., Resident C was observed seated in a recliner chair with his feet elevated, in the lounge area of the secured memory care unit (MCU). His eyes were closed and breathing was easy and non-labored.On 5/18/26 at 12:38 P.M., Resident C was observed seated in the recliner chair with his feet down, in the lounge area of the secured MCU. His eyes were closed and he was wearing oxygen per nasal cannula. His skin color was ashen, and his respirations were labored and irregular. The Nurse Practitioner (NP) was present. Both she and Licensed Practical Nurse (LPN) 2 were on the phone trying to contact the resident's family. The NP indicated the resident had a change in condition and was declining rapidly. She was trying to contact the resident's family to see what their wishes were for hospitalization but could not contact them. The NP indicated the resident was a full code so was ordering the facility to send him to the hospital for evaluation and treatment.Resident C's record was reviewed on 5/18/26 at 12:01 P.M. Diagnoses included dementia and obstructive hydrocephalus (blockage preventing fluid from flowing normally through the brain).A nurse note, dated 5/13/26 at 12:50 p.m., indicated Resident C vomited a very dark colored substance. The Assistant Director of Nursing (ADON) was notified, she assessed the resident and substance vomited. She advised LPN 2 to give milk of magnesia, as ordered, for no bowel movement. The ADON indicated she would contact the Nurse Practitioner (NP) for an order for abdominal x-ray.There was no assessment of the resident or substance he had vomited, documented in the record. There was no documentation indicating the NP had been notified of Resident C vomiting and the dark colored substance observed.A nurse note, dated 5/13/26 at 7:54 p.m., indicated Resident C had been up for supper but had decreased intake. The abdominal x-ray had been completed, as ordered. He had no further vomiting of BM (bowel movement/stool).A Critical abdominal x-ray result, reported on 5/13/26 at 6:29 p.m., indicated there was considerable distention of the colon which appeared to be due to a non-specific ileus (slowed bowel function).There was no documentation in the clinical record indicating the NP had been notified of the critical abdominal x-ray results at the time they were received. An NP progress note, dated 5/19/26 for a visit which occurred 5/14/26, indicated Resident C was seen for abnormal abdominal x-rays. An abdominal x-ray had been obtained due to an episode of dark in color vomiting. Resident C was visited while seated in the common area (lounge). He hadn't appeared in any distress and denied abdominal pain. His abdomen was soft, non-distended and non-tender, with normal bowel sounds. Treatment for ileus was to give Lactulose by mouth 2 times/day X 5 days for constipation and Reglan 3 times per day x 5 days (increases intestinal (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	movement). Resident C was to have clear liquids for 24 hours, extra fluids, and a repeat abdominal x-ray. Labs had been drawn and the NP was waiting on results of complete blood count (CBC) and comprehensive metabolic panel (CMP). Labs were to be repeated on 5/18/26. Staff were to call the NP with any further vomiting or abnormal vital signs.There was no order in Resident C's physician orders, on the Treatment Administration Record (TAR), or referenced in nurse notes to indicate a new order to repeat the resident's labs on 5/18/26 had been received. A physician order, dated 5/14/26, was for an abdominal x-ray to be done the morning of 5/15/26 for diagnosis of Ileus.There was no documentation in Resident C's record (Medication Record, Treatment Record, Progress Notes, or event documentation) indicating an abdominal x-ray had been completed on 5/15/26. There were no assessments of bowel sounds, abdominal distention, abdominal pain, or increased fluid intakes documented in the record (Medication Record, Treatment Record, Progress Notes, or event documentation) between 5/14/26 and 5/18/26.A nurse note, dated 5/18/26 at 1:18 p.m., indicated Resident C was observed with shortness of breath and was difficult to arouse from sleep. His oxygen saturation was 65% (normal >90%) and his pulse was irregular at 101 beats per minute (bpm) (normal 60-80 bpm). Oxygen at 2 liters per nasal cannula was administered and the NP was notified. Attempts were made to contact family but were unable to be reached. The resident was sent to the hospital due to rapid decline in condition.The Director of Nursing (DON) was interviewed on 5/18/26 at 1:18 P.M. She indicated the follow-up abdominal x-ray, to have been completed on 5/15/26, had not been done as ordered.LPN 2 was interviewed on 5/19/26 at 10:06 A.M. She had just spoken with the hospital nurse and was told Resident C was in the ICU with a diagnosis of bowel perforation (a tear in the wall of the colon). LPN 2 indicated an abdominal x-ray was ordered to be done on 5/15/26 but hadn't been completed due to an error with scheduling. LPN 2 indicated she had not been aware of the 2-step process required when scheduling x-rays and had only completed step 1 therefore, the x-ray was not done.The Regional Nurse Consultant (RNC) was interviewed on 5/19/26 at 12:30 P.M. She indicated nurses should have assessed and documented Resident C's condition as it related to the ileus including assessment of further vomiting, abdominal pain, distention, bowel sounds, and food and fluid intakes.Hospital ER records, dated 5/18/26 at 12:58 p.m., indicated Resident C arrived at the emergency room, unresponsive, profoundly hypotensive (low blood pressure) at 55/24 (normal 120/80), with poor blood flow and dusky feet. His abdomen was distended and he had brown stool in his brief. A chest x-ray showed a large amount of free fluid in his abdomen. He was diagnosed with Pneumoperitoneum (abnormal fluid or gas in the abdominal cavity), respiratory failure, and septic shock. He was sent emergently to the operating room where he was observed with a sigmoid colon (lower left side of abdomen/bowel) perforation. After surgery he was admitted to the intensive care unit where he later died on 5/19/26 at unknown time.Standards of Nursing Care for diagnosed ileus was retrieved from nursetogether.com on 5/20/26 at 9:15 A.M. which indicated nurses should assess and monitor the abdomen for abdominal discomfort due to bloating and distension; palpate the abdomen for tenderness; check bowel sounds with stethoscope for decreased sounds; monitor bowel movements and passing of gas; measure the abdominal girth for increasing size indicating worsening distention; and monitor and record vital signs such as low blood pressure or elevated heart rate which could indicate shock requiring immediate emergency care.Current facility policies, titled Change in Condition/Physician Notification and Physician Orders were provided on 5/20/26 at 12:38 P.M. by the DON. Change in Condition/Physician Notification policy indicated significant changes in a resident's condition should be reported to the physician/NP within 24 hours and the Charge Nurse was to document the change, interventions, and notifications timely. Physician Orders policy indicated the purpose was to provide a reliable process for proper and consistent provision of physician ordered services according to professional standards of quality. The facility was to maintain a schedule of diagnostic tests in accordance with the physician's orders. Nursing personnel were to submit timely requests for physician ordered services (labs, x-rays) to the appropriate entity. Upon receipt of critical lab or x-ray result reports, nurses were to communicate the results to the ordering provider for (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediate attention. Nursing personnel were to document diagnostic test results and date/time of physician notification in the resident's record.A request for a policy indicating how the facility monitored and assessed acute significant changes was not provided. No policy was available at exit regarding assessments and monitoring after change of condition. The Immediate Jeopardy that began on 5/15/26 was removed on 5/20/26 when the facility re-educated floor nurses on facility policies for change in condition, physical assessments for GI (gastrointestinal) complaints and process for entering labs/x-rays in the facility designated system but will remain at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.This Citation relates to Intake 3014046.410 IAC (Indiana Administrative Code) 16.2-3.1-37