

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Majestic Care of Jefferson Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document, monitor and report changes in a skin condition for 1 of 3 residents reviewed (Resident B). Findings include: Resident B's record was reviewed on 7/20/26 at 9:51 AM. Diagnoses included end stage renal disease, dependance on renal dialysis, diabetes type 2, and chronic peripheral renal insufficiency and arterial stenosis. A current significant change Minimum Data Set assessment (MDS), dated [DATE], indicated Resident B had a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). A progress note, dated 7/1/26 8:59 PM, indicated Resident B was seen by Nurse Practitioner (NP) 3 for a follow up visit related to bilateral lower leg cellulitis. NP 3 indicated the cellulitis was improving and no seeping or drainage was noted. No additional progress notes describing the condition of Resident B's lower legs were available for review. A skin assessment dated [DATE] indicated there were no new skin areas. A transfer form, dated 7/15/26 at 11:21 AM, indicated Resident B was sent to the hospital for shortness of breath, decline in blood pressure and elevated temperature. The transfer form indicated Resident B had skin areas on her hips and edema of the lower extremities that could seep. A skin condition evaluation form, dated 7/14/26, indicated Resident B had wounds on her left thigh, left trochanter (hip), left lateral thigh, right thigh (rear), and no other wounds. A resident care team review, dated 7/14/26, indicated Resident B received education to lie down in bed to promote wound healing and indicated Resident B refused to sleep in the bed, sleeping in a wheelchair instead. The note did not mention any open areas, weeping edema of the lower legs, or elevation of legs while in the wheelchair. A current care plan, titled smoking, indicated Resident B had a problem of smoking cigarettes, with a goal date of 9/3/26. Interventions included using designated areas to smoke. A current policy, titled Smoking, provided by the Regional Nurse Consultant (RNC) on 7/20/26 at 2:51 PM indicated smoking was only permitted in a designated outdoor area. A current care plan indicated Resident B had a problem of risk of skin breakdown related to weeping edema with a goal date of 9/3/26. Interventions included weekly skin assessments with documentation and physician notification of changes. A current physician order, dated 6/17/26, indicated Resident B's bilateral lower extremities should be washed, patted dry and then short-stretch compression wraps should be applied. A treatment administration record, dated July 2026, did not contain documentation of application of short stretch compression wraps on 7/1/26, 7/2/26, 7/3/26, 7/7/26, and 7/12/26. A wound care document, dated 7/16/26 11:00 AM, provided by the hospital medical records department on 7/20/26 at 2:05 PM, indicated Resident B had a closed, non-pressure venous ulcer under a dressing on Resident B's lower right leg. A photograph dated 7/15/26 7:08 PM contained dark pink skin with yellowish slough and a melon-colored sponge dressing rolled partially open beside the area. In an interview, on 7/20/26 at 3:18 PM, Licensed Practical Nurse (LPN) 2 indicated Resident B had a large amount of bilateral lower extremity edema. LPN 2 indicated Resident B prioritized smoking (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and often went to the smoking area before staff could apply ordered dressings to her legs. LPN 2 indicated Resident B had taken her dressings off at times because they were wet or tight and did not notify staff. LPN 2 indicated staff sometimes had a hard time finding Resident B after she left the unit to smoke. LPN 2 indicated she did not know why sign off boxes for Resident B's leg treatments were not signed on 7/1/26, 7/2/26, 7/3/26, 7/7/26, 7/12/26. LPN 2 indicated staff should note any refusals of care or any occurrence of Resident B's removal of dressings in the progress notes. LPN 2 indicated the care plan should address Resident B's removal of dressings. In an interview, on 7/21/26 at 9:19 AM, LPN 2 indicated on the morning of 7/15/26, Resident B was outside smoking when LPN 2 arrived for work at 6:00 AM. LPN 2 indicated Resident B normally started dialysis around 6:30 AM, so dressing changes were typically done after dialysis LPN 2 indicated Resident B frequently removed her leg dressings or asked other residents to remove them for her when the dressings became uncomfortable and did not tell staff when the dressings were removed. LPN 2 indicated Resident B approached her before dialysis, complaining of seeping on her right lower leg, asking for some padding to be placed in the area before she started dialysis. LPN 2 indicated she rinsed the area with wound wash quickly, applied a small gauze pad and Mepilex (a melon-colored absorbent, sponge wound dressing) to contain the seeping. LPN 2 indicated she was unable to see an open skin area of the right lower leg prior to applying the pad. LPN 2 indicated she did not provide education to Resident B about the risk of flies or other insects when spending time outdoors with uncovered open skin areas. LPN 2 indicated she was not aware of any education about the risk of flies by any other staff member. A current policy, titled Wound Care Policy, dated 3/17/26, provided by the RNC on 7/20/26 at 4:23 PM, indicated Residents with skin integrity problems were recognized by the care team, and healing interventions were exhausted until the skin was healed. The policy indicated staff should act to prevent infection of impaired skin areas. A current policy, titled Change in Condition/Physician Notification, dated 3/19/25, provided by the Administrator on 7/21/26 at 10:38 AM, indicated when a change in condition is discovered, the nurse should evaluate the resident and report pertinent findings to the physician. 410 IAC 16.2-3.1-37(a)		