Katlyn

PRINTED: 03/30/2023
FORM APPROVED

03/08/2023

	R MEDICARE & MEDIC						IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			a. building <u>00</u>			COMPLETED	
155570		B. WING			02/21	/2023	
NAME OF 1	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP COD	-	
					ANE RD		
MAJEST	TIC CARE OF MCC	ORDSVILLE	M	ICCORI	DSVILLE, IN 46055		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
Blug. 00	This visit was for the Investigation of Complaint IN00401721. Complaint IN00401721 - Substantiated. Federal/state deficiency related to the allegations is cited at F921.		F 0000		We respectfully request that t	his	
			1 0000		plan of correction be consider		
					· for a desk review in lieu of a p		
					survey revisit. Thank you.		
	Current datas. Esh	magra 20 and 21, 2022					
	Survey dates: Febr	ruary 20 and 21, 2023					
	Facility number: 0	000477					
	Provider number:	155570					
	AIM number: 100	290860					
	C DIT						
	Census Bed Type: SNF/NF: 37						
	Total: 37						
	Total. 37						
	Census Payor Type	2:					
	Medicare: 6						
	Medicaid: 19						
	Other: 12						
	Total: 37						
	This deficiency ref	lects State Findings cited in					
	accordance with 41						
	quality review com	pleted on February 24, 2023					
E 0024	402.00(1)						
F 0921 SS=D	483.90(i)	Capitan /Camfartable Environ					
Bldg. 00		Sanitary/Comfortable Environ					
ычу. 00	- ','	Environmental Conditions provide a safe, functional,					
		nfortable environment for					
	residents, staff ar						
		on, interview and record	F 0921		1. What corrective action		03/08/2023
		failed to ensure a resident's	1 0,21		will be accomplished for tho	se	03, 00, 2023
		afe environment as evidenced			residents found to have bee		
	<u> </u>						<u> </u>
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE		TITLE		(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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Collins

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
15		155570	B. WING			02/21/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				LANE RD		
MAJEST	IC CARE OF MCCC	DRDSVILLE			RDSVILLE, IN 46055		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
		nt to a resident's bed, had 4			affected by the deficient		
	screws extending from the wall that could be a				practice;		
	potential hazard for a resident. (Resident) Findings include: During a tour of random resident rooms with the				a. All residents affected b	·	
					the deficient practice had no		
					negative outcomes.		
					b. Room with identified is:		
					was immediately repaired ar		
	Maintenance Director on 2-20-23 at 10:30 a.m.,				all other rooms in the facility		
		ved to have a piece of painted			have been checked for safet	у	
		ned to the wall, adjacent to the			hazards.		
	_	th of the bed was positioned					
	adjacent to the wall covering with the exposed				2. How other residents		
		rtion of the wall covering was			having the potential to be		
	located approximately four feet from the floor and				affected by the same deficie	nt	
	had 4 screws in a linear pattern, spaced about 6 to				practice will be identified an	d	
	12 inches apart, near the top portion of the wall				what corrective actions have	9	
	-	erview with Resident F at this			been taken;		
	time, he indicated it appeared to him the screws				a. All residents have the		
	were about one-eighth of an inch from being flush				potential to be affected by the	ne	
	with the wall and could be a potential hazard for				deficient practice. Room aud	dits	
		or clothing. He indicated he			were completed by		
	_	ns with such as he is able to			maintenance supervisor to		
	keep his arms and b	ody parts away from the			ensure the environment is		
	screws.				appropriate and that there a	re	
					no immediate maintenance		
		the Maintenance Director on			needs to be addressed.		
		n., he indicated he had noticed					
	the screws in this room at that area were not flush				3. What measures will be		
	with the wall the previous week, but had not				put into place or what syster	mic	
	-	out would get it fixed as soon			changes will be made to		
		lained in the last week, there			ensure the deficient practice	•	
	-	oom moves and prior to the the			does not recur;		
	· ·	d had been located in a			a. Maintenance departme		
		d of the bed had been directly			will conduct 5 room audits a		
		nis wall covering, not as it			facility walkthroughs weekly	x4	
	currently was located with the length of the bed				and then monthly x4, and		
	being adjacent to th	e wall covering.			quarterly thereafter.		
	-				b. Magic ambassadors		
		nt F's clinical record on 2-20-23			assigned to each room will		
at 12:30 p.m., indicated he was cognitively intact.					check rooms daily for repair	s	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155570	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/21/2023			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF MCCORDSVILLE			•	STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055					
(X4) ID PREFIX TAG	(EACH DEFICIEN	MARY STATEMENT OF DEFICIENCIE FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE			
		ates to Complaint IN00401721.		IAU	needed and report to maintenance. c. All staff were inservice on how to put in a maintenance request and to report to maintenance/management team when seeing immediat maintenance needs in reside rooms/areas. 4. How the corrective activity will be monitored to ensure deficient practice will not recur, i.e. what quality assurance program will be pinto place; a. Maintenance departme will conduct 5 room audits a facility walkthroughs to ensure there are no outstanding maintenance needs weekly and then monthly x4, and quarterly thereafter. If 100% compliance is not obtained a action plan will be developed and reviewed by the monthly QAPI committee.	e ent ion the nt ind ure x4	DAIL		

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