PRINTED: 06/07/2023

DEPARTMENT	FO	RM APPROVED					
CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPI	
		155243	B. W	'ING		05/08	/2023
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAYETTE, IN 47905			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROP			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
Diag. 00		ne Investigation of Complaints 405075 and IN00406151.	F 0	000			
	•	6869 - Federal/state deficiencies ations are cited at F684, F690					
	_	5075 - Federal/state deficiencies ations are cited at F684.					
	Complaint IN00400 the allegations are of	6151 - No deficiencies related to cited.					
	Survey dates: May	3, 4, 5 and 8, 2023					
	Facility number: 00	00147					
	Provider number: 1						
	AIM number: 1002	66900					
	Census Bed Type: SNF/NF: 98 Total: 98						
	Census Payor Type Medicare: 5 Medicaid: 89 Other: 4 Total: 98	:					
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review was completed on May 16, 2023.

TITLE

(X6) DATE

Emily D Cook

483.25

Quality of Care

§ 483.25 Quality of care

F 0684

SS=D

Bldg. 00

**Director of Nursing Services** 

05/26/2023

Any defiencystatement 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3D0P11 Facility ID: 000147 If continuation sheet Page 1 of 12

CENTERS	FOR MEDICARE & MEDIC				OMB NO. 0938-039	
STATE	MENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155243	B. WING		05/08/2023	
			CER PET	A DDD EGG CHTM CTATE THE COD		
NAME	OF PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
N4A 15		VETTE	300 WINDY HILL DR			
MAJE	STIC CARE OF LAFA	YEIIE	LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Quality of care is	a fundamental principle that				
	applies to all treat	ment and care provided to				
	facility residents.	Based on the				
	comprehensive as	ssessment of a resident, the				
	facility must ensur	re that residents receive				
	treatment and car	e in accordance with				
	professional stand	dards of practice, the				
	1 · ·	erson-centered care plan,				
	and the residents	•				
	Based on interview	and record review, the facility	F 0684	Deficiency ID: F 684: Quality of	of 05/24/2023	
	l l	ound treatment and wound		Care	****	
	interventions as ord	lered by the physician for 2 of		Completion Date: 5/24/23		
	3 residents reviewe	d for quality of care.		Plan of Correction:		
	(Residents D and B			What corrective action will be		
	`	,		accomplished for those reside	nts	
	Findings include:			found to have been affected by		
				deficient practice:	,	
	1. The record for R	esident D was reviewed on		Resident D had wound		
	5/5/2023 at 1:55 p.i	m. Diagnoses included, but were		treatment to the LLL. MAR		
		pressure chronic ulcer of		indicated that the treatment wa	as	
		left lower leg (LLL) with fat		not completed on 3/20/23. A n		
		gestive heart failure, peripheral		from the wound care center or		
	1 ' '	ifficiency, type 2 diabetes		3/23/23 indicated the resident		
		llation, localized edema, and		sent to the hospital for evaluat		
		and thrombosis of unspecified		Resident B had two stag		
	vein.	1		pressure ulcers which were		
				present upon admission and w	/as	
	An admission Mini	mum Data Set (MDS)		to receive sacrum wound care		
	l l	2/28/23, indicated the resident		daily. The MAR indicated that		
	l l	l arterial ulcer and required		resident had not received wou		
	l l	l person for personal hygiene.		treatment to his sacrum on 3/1		
		1 1		3/12, 3/27 and 3/29.	• ,	
	A care plan indicate	ed Resident D had symptoms		Resident B was to receive	/e	
		entions included, but were not		wound care to his left calf and		
		for edema, observe for signs of		MAR indicated this care was n		
	infection, and treati			given on 3/11, 3/12, 3/19, 3/26		
	iniconon, and treat	and ordered.		3/27, and 4/3.	',	
	The Medication Ad	lministration Record (MAR)		Resident B was to receive	/e	
	l l	D was to receive LLL		Dakin's (1/2 strength) to the		
	marcarea Resident	D Was to receive LLL	1	Dakins ( 1/2 sirengin) to the	1	

treatment, to cleanse with normal saline, pat dry,

sacrum and left calf and the MAR

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155243	B. W	'ING		05/08/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
	T		1		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	OM
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETIC	UN
TAG		LISC IDENTIFYING INFORMATION alginate to the wound, and to		TAG			
		-			indicated this treatment was n	Ol	
	apply zinc oxide to the peri wound. Cover the wound with super absorbent dressing. Cover both				completed on the day shift on		
	-				3/11, 3/12, 3/26, and 3/27.		
	legs with 3-layer compression wraps. Change the				Resident B was to receive	/e	
	dressing every Monday on the day shift related to				betadine to right heel and the		
	the non-pressure chronic ulcer of the unspecified				MAR indicated the resident was not given the wound care on 3		
	part of the LLL with fat exposed. The MAR indicated the treatment was not completed on					711,	
	3/20/2023.	ient was not completed on			3/12, 3/19, 3/26, 3/27  Resident B was to recei	/B	
	J1 201 2023.				barrier cream to the buttocks		
	A note from the wo	und care center on 3/23/2023			and the MAR indicated the	aany	
	A note from the wound care center, on 3/23/2023, indicated the resident was sent to the hospital for				resident was not given the		
	evaluation of possible cellulitis.				treatment on 3/4, 3/11, 3/12, 3/	10	
	evaluation of possible cellulius.				3/27, and 4/4.	19,	
	During an interview	y, on 5/8/2023 at 1:16 p.m., with			Resident B was to recei	/A	
	_	al Staff (RCS), DON and			dry absorbent pad to the groin		
	_	RCS indicated the treatment			the MAR indicated this treatm		
		nented as completed. Staff			was not received on 3/11, 3/1		
		he possible cellulitis until the			4/3, and 4/4.	<del>-</del> ,	
		3/2023, the resident had been			Resident B was to recei	/A	
		for further evaluation from the			sacral cleanse and treatment		
	wound clinic.	for further evaraution from the			the MAR indicated this was no		
	would clime.				given on 4/4.		
	2. The record for Re	esident B was reviewed on			Resident B was to have		
		n. Diagnoses included, but were			pressure reduction boots at al		
	_	ired absence of right upper			times while in bed. The MAR		
	_	w, pressure ulcer sacral region			indicated that the resident was	s not	
		opathy, flaccid neuropathic			checked to have the pressure	·	
		status, other disorders of the			boots on 3/4, 3/11, 3/12, 3/19,		
		peripheral vascular disease,			4/3, and 4/4 and on the evening		
	and venous insuffic				shift of 3/18 and 4/15, and on	-	
		-			night shift on 4/9.		
	An annual Minimur	n Data Set (MDS) assessment,			Resident B was to recei	/e	
	dated 3/17/23, indic	eated the resident was an			monitoring and adjustment of	the	
		assist for toileting, an			low airloss mattress. The MAF		
	_	assist for personal hygiene,			indicated that this was not give	en	
	_	pressure ulcers which were			on dayshift on ¾, 3/11, 3/12, 3		
	present on admission	-			4/3, 4/4, on the evening shift of		
					4/15, and on the night shift on		
	A care plan indicate	ed Resident B had impaired			· There was no harm to e		

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DEPARTMEN CENTERS FO		IB NO. 0938-039					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	LETED	
		155243	B. WING		05/08	/2023	
NAME OF	DD OLUBED OD GUDDU IEI		STREE	TT ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	ę.	300 V	WINDY HILL DR			
MAJEST	TIC CARE OF LAFA	YETTE	LAFA	YETTE, IN 47905			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	skin integrity to the	buttocks related to moisture		resident.			
		nage. Interventions included,		How other residents having the	he		
		d to, assess and document skin		potential to be affected by the	9		
	condition, and wound treatment as ordered.			same deficient practice will be	е		
				identified and what corrective	;		
	_	ed Resident B had impaired		action will be taken.			
		e left calf related to a		· All Residents with wour	nd		
		Interventions included, but		care orders or wound care			
		assess and document skin		prevention orders have the			
	condition, and wou	nd treatment as ordered.		potential to be affected.			
				· The wound care nurse			
	A care plan indicated Resident B had impaired			round on all new admissions			
	skin integrity related to a right heel pressure ulcer.			readmissions prior to the nex			
		ded, but were not limited to,		morning IDT and performs a			
		nt skin condition, and wound		to toe assessment in order to			
	treatment as ordered	d.		identify residents will commu	-		
				acquired wounds and to asse			
	_	ed Resident B had impaired		for the risk of skin breakdowr			
		d to a sacrum pressure ulcer.		wound care nurse updates care			
		ded, but were not limited to,		plan and floor nurse of any needed			
		nt skin condition, and wound		interventions to prevent skin			
	treatment as ordered	d.		breakdown.			
		ID 11 (D1 1		Monthly skin sweeps a	·e		
	_	ed Resident B had symptoms		performed by nurse leaders			
		n. Interventions included, but		· What measures will be			
		, notify MD of worsening or		into place and what systemic			
	_	on, document abnormal		changes will be made to ensu			
	findings, and treatn	nent as ordered.		that the deficient practice doe	es not		
	The MAD in director	1 D: 14 D 4		occur			
		d Resident B was to receive		· Education has been			
		daily, and to cleanse with		provided to all nurses including	-		
		ium alginate with silver and		wound care policy, wound ca			
		gauze to the wound bed, and to bent dressing. Apply zinc		procedures and skin manage	пепі.		
		isture-Associated Skin		· Unit managers are	dailu		
		The MAR indicated the		performing MAR/TAR audits	-		
	- '	ven the wound care on 3/11,		during IDT meetings to ensur			
	3/12, 3/27 and 3/29			residents are both receiving of	are		
	3/12, 3/2/ and 3/29	12023.	1	per MD orders and that it is		1	

The MAR indicated Resident B was to receive

documented correctly.

Nurse managers will audit

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	ETED
		155243	B. W	ING		05/08/2	2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
	1				, I	Г	OLE:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION eft calf, to cleanse with wound	-	TAG			DATE
		oply calcium alginate to the			wound treatments during IDT	امر	
					rounds to ensure that the wou		
	wound and to cover with super absorbent dressing, roll gauze, and stretchnet. Change daily.				treatment was completed and dated with the correct date.		
	The MAR indicated the resident was not given				Nurse managers will au	dit	
		3/11, 3/12, 3/19, 3/26, 3/27 and			care plans during IDT meeting		
	4/3/2023.	3/11, 3/12, 3/17, 3/20, 3/27 and			ensure that each wound and	JS 10	
	1/3/2023.				intervention is care planned.		
	The MAR indicated Resident B was to receive				Nurse managers will au	dit	
	Dakin's (1/2 strength) solution 0.25% (sodium				wound interventions daily duri		
	hypochlorite), to apply to the sacrum and left calf				IDT rounds.	9	
	topically every dayshift. The MAR indicated the				· All residents with wound	ı	
	treatment was not completed on the dayshift on				care orders will receive wound	d l	
	3/11, 3/12, 3/26, and 3/27/2023.				care as ordered.		
					How the corrective action	n	
	The MAR indicated	l Resident B was to receive			will be monitored to ensure the	e	
	betadine external so	olution, to apply to the right			deficient practice will not recu	r,	
	heel topically every	dayshift. Cleanse with wound			what quality assurance progra	am	
	cleanser, apply skin	prep to the peri-wound, apply			will be put into place:		
	betadine moistened	gauze, and change daily. The			· The nurse managers wil	II	
	MAR indicated the	resident was not given the			audit wound care treatments f	or	
	wound care on 3/11	, 3/12, 3/19, 3/26, 3/27 and			correct dates, presence of		
	4/4/2023.				interventions five days a week	c for	
					60 days, weekly for 60 days, a	and	
		l Resident B was to receive			monthly for 60 days.		
		arrier external cream 1.3%, to			· Review each month in		
		as topically every day. The			QAPI.		
		resident was not given the					
	care on 3/4, 3/11, 3/	/12, 3/19, 3/27 and 4/4/2023.					
	The MAD indicated	l Resident B was to receive +					
		or equivalent to the left					
		to manage moisture once a					
	~	cated the resident was not					
	-	/11, 3/12, 4/3 and 4/4/2023.					
	gron the care on 3/	11, 5, 12, 1/5 and 1/7/2025.					
	The MAR indicated	l Resident B was to receive a					
	sacrum cleanse with	n wound cleanser. To apply					
		ne wound bed, cover with an					
	_	and to apply zinc ointment to					

3D0P11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		a. building <u>00</u>			COMPL	3) DATE SURVEY COMPLETED 05/08/2023	
	PROVIDER OR SUPPLIER			300 WIN	DDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
mo		AR indicated the resident was		1710			Dille
	pressure reduction l bed. The MAR indi checked to have the the dayshift on 3/4,	A Resident B was to have boots on at all times while in scated the resident was not be pressure reduction boots on 3/11, 3/12, 3/19 4/3 and 4/4, on a 3/18 and 4/15, and on the 023.					
	monitoring and adjust mattress with setting The MAR indicated the care on the days	I Resident B was to receive ustment of the low air loss gs per the resident's weight. If the resident was not given shift on 3/4, 3/11, 3/12, 3/19, 4/3 ming shift on 4/15, and on the 123.					
	resident was sent to when his scrotum a	ed 4/18/2023, indicated the the hospital for evaluation rea appeared edematous and k area to the right side of his					
	the resident was add	ote, dated 4/15/2023, indicated mitted for a diagnosis of e of penile and scrotal area.					
	the Regional Clinic Wound Nurse, the I had not been docun MARs had not beer was not aware if the performed or not be to document every completed per the p	•					
	A current facility po	olicy, titled "Abuse Prevention					

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Event ID:

3D0P11 Facility ID: 000147

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				LETED
		155243	B. W	ING		05/08	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
							1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		last revised March 2021 and					
		executive Director on 5/4/23 at					
	-	l"Neglect is the failure of the					
		ees or service providers to					
		service to a resident that are					
		physical harm, pain, mental					
	anguish or mental il	llness"					
	A current facility po	-					
	-	d October 2019 and received					
		Director on 5/8/23 at 2:40 p.m.,					
indicated "Residents identified at risk for skin							
	breakdown will have appropriate prevention interventions put into place"						
	interventions put in	to place					
	This Federal tag rela	ates to Complaints IN00406869					
	and IN00405075.						
	3.1-37(a)						
F 0690	483.25(e)(1)-(3)						
SS=D	` , ` , ` ,	continence, Catheter, UTI					
Bldg. 00	§483.25(e) Inconti						
J	` ' '	facility must ensure that					
		entinent of bladder and					
		on receives services and					
	assistance to mair	ntain continence unless his					
		dition is or becomes such					
		not possible to maintain.					
		·					
	§483.25(e)(2)For a	a resident with urinary					
	incontinence, base	ed on the resident's					
	comprehensive as	ssessment, the facility must					
	ensure that-						
	(i) A resident who	enters the facility without					
	an indwelling cath	eter is not catheterized					
	unless the residen	nt's clinical condition					
	demonstrates that	catheterization was					
	necessary;						
	(ii) A resident who	enters the facility with an					

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Event ID:

3D0P11 Facility ID: 000147

If continuation sheet Page 7 of 12

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION NUM 155243		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	(X3) DATE SURVEY  COMPLETED  05/08/2023	
	PROVIDER OR SUPPLIEI		300 W	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR 'ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	one is assessed f as soon as possible clinical condition of catheterization is (iii) A resident where receives appropriate to prevent urinary restore continence. §483.25(e)(3) For incontinence, base comprehensive as ensure that a resist bowel receives appropriate to prevent urinary restore continence. §483.25(e)(3) For incontinence, base comprehensive as ensure that a resist bowel receives appropriate to restore function as possible Based on interview failed to provide For the physician for 1 catheter care. (Resistent of the physician for 1 catheter care. (Resistent of the care to the physician for 1 catheter care. (Resistent of the care to the physician for 1 catheter care.) The record for Resistent of the care to the physician for 1 catheter care. (Resistent of the care to the physician for 1 catheter care.) An annual Minimum dated 3/17/23, indicextensive 2 person extensive 2 person and had an indwelling the properties of the care to the physician for 1 catheter care.	o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible.  The a resident with fecal ed on the resident's assessment, the facility must dent who is incontinent of a propriate treatment and e as much normal bowel ole.  The and record review, the facility oley catheter care as ordered by of 3 residents reviewed for dent B)  The analysis of the facility of the facility oley catheter care as ordered by of 3 residents reviewed for dent B)  The analysis of the facility of the facility oley catheter care as ordered by of 3 residents reviewed for dent B)  The analysis of the facility of the facility oley catheter care as ordered by of 3 residents reviewed for dent B)  The analysis of the facility of the facility oley catheter care as ordered by of 3 residents reviewed for dent B)	F 0690	Deficiency ID: F 691: Bowel/Bladder Incontinence, Catheter, UTI Completion Date: Plan of Correction: 5/24/23 What corrective action will be accomplished for those residen found to have been affected by deficient practice:  Resident B was found to have not had documented foley catheter care, foley catheter flu with acetic acid, or a privacy ba for the foley catheter over seve days.  There was no harm to the resident How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken	the  / sh ag ral	

FORM CMS-2567(02-99) Previous Versions Obsolete

infection/complications related to an indwelling

Event ID:

3D0P11

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If continuation sheet

Residents will be identified

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CENTERS FOR	R MEDICARE & MEDIC					OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155243	B. W	'ING		05/08	/2023
NAME OF P	DDOMINED OF STIRRITER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			300 WI	NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIS DI ANI OE CORDECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	catheter and neurog	enic bladder. Interventions			by most recent MDS.		
	included, but were i	not limited to, document			· All new residents and		
	catheter output ever	y shift, catheter and peri-care			readmissions will be reviewed	in	
	at least every shift a	and as needed and keep			IDT meeting for foley catheter	s or	
	drainage bag and tu	bing below the level of the			other urinary devices.		
	bladder.				What measures will be put into		
					place and what systemic chan	_	
		ministration Record (MAR)			will be made to ensure that the	е	
		B was to have the Foley			deficient practice does not occ	cur	
		inage bag covered for privacy			· Education has been		
		MAR indicated this was not			provided to all nurses includin	g the	
	completed on the day shift on 3/4, 3/11, 3/12, 3/19,				policy on foley catheter care.		
		evening shift on 3/18/2023 and			· Unit managers are		
	4/15, and on the nig	tht shift on 4/9/2023.			performing MAR/TAR audits d	-	
					during IDT meetings to ensure	the	
		Resident B was to receive			residents are both receiving ca	are	
		on every shift. The MAR			per MD orders and that it is		
		nt did not receive Foley			documented correctly.		
		day shift on 3/4, 3/11, 3/12,			· All residents with foley		
		n the evening shift 3/18 and			catheters will receive care as		
	4/15, and on the nig	tht shift on 4/9/2023.			ordered.		
					How the corrective action will		
		Resident B was to have the			monitored to ensure the defici		
	, ,	ated with 60 ml (milliliters) of			practice will not recur, what qu	-	
	1	ne MAR indicated the resident			assurance program will be put	into	
	was not given this in	rrigation on 3/4/2023.			place:		
	TEL MARKET III	In the n			The unit managers will		
		Resident B was to receive			perform MAR/TAR audits duri	-	
		5%, to insert 60 cc in the			each morning IDT meeting as		
		The MAR indicated the			standard practice to ensure th		
	_	ven this care on 3/4, 3/11, 3/12,			care is both provided as order	ed	
	3/19, 3/26, 3/27, 3/2	28, 4/3, and 4/4/2023.			and documented as required.		
	Daning a Color	5/9/2022 -4 1 20			The nurse managers wil		
	_	y, on 5/8/2023 at 1:20 p.m., with			audit catheters during IDT rou		
	_	al Staff (RCS), DON and			daily for 60 days and then wee	-	
		RCS indicated the MAR had			for 60 days and monthly for 60		
		ed correctly. He was not aware			days. Catheter care will be au		
		tments had been performed or			by observing for catheter tubir	-	
	not been performed	. The staff were to document			secured and not kinked with a	n	

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every procedure which had been completed per

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unobstructed flow, output reported

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  05/08/2023		
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR YETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0691 SS=D Bldg. 00	Program," dated as received from the E 1:55 p.m., indicated facility, its employe provide goods and s necessary to avoid panguish or mental il This Federal tag relations and the second state of the second s	omy, or Ileostomy Care		each shift, that the bag is kept below bladder level, tubing an bag are not in contact with the floor and a basin is in place if resident is in a low bed, a priv bag is being utilized, and that catheter care is performed each shift.  Results will be shared in Quimeeting monthly.	d the acy ch
	Based on interview failed to provide corphysician for 1 of 3 colostomy care. (ReFindings include:  The record for Residual 1:03 p.r. not limited to, acquillimb below the elborstage 4, cardiomyo bladder, colostomy	dent B was reviewed on  n. Diagnoses included, but were ired absence of right upper w, pressure ulcer sacral region opathy, flaccid neuropathic status, other disorders of the peripheral vascular disease,	F 0691	Deficiency ID: F 691: Colostor Urostomy, or Ileostomy care Completion Date: 5/24/23 Plan of Correction: What corrective action will be accomplished for those reside found to have been affected be deficient practice:  Resident B was found to have not had documented colostom care every shift as needed.  There was no harm to the resident.  How other residents having the	nts y the ive iy

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DEPARTMEN CENTERS FO		ORM APPROVED MB NO. 0938-039				
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMP	PLETED
		155243	B. WING		05/08	3/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R		INDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE	LAFA	YETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				potential to be affected by the		
		m Data Set (MDS) assessment,		same deficient practice will	be	
	· ·	cated the resident was an		identified and what corrective	'e	
	_	assist for toileting, an		action will be taken.		
	_	assist for personal hygiene,		·Residents will be identifie	d by	
	and had a colostom	ıy.		most recent MDS.		
				·All new residents and		
		ed Resident B had an alteration		readmissions will be reviewe	ed in	
		status related to a colostomy		IDT meeting for bowel device	es.	
	^	the intestine and a history of a				
	fistula of the intestine. Interventions included, but			What measures will be put i	nto	
	were not limited to	, colostomy care as ordered and		place and what systemic ch	anges	
	as needed.			will be made to ensure that	the	
				deficient practice does not o	ccur:	
	The Medication Ad	lministration Record (MAR)		·Education has been prov	ided to	
	indicated Resident	B was to receive colostomy		all nurses including the police	cy of	
	care every shift and	d as needed. The MAR		colostomy care.		
	indicated the reside	ent was not given colostomy		·Unit managers are perfor	ming	
	care on the day shift	ft on 3/4, 3/11, 3/12, 3/19, 4/3		MAR/TAR audits daily durin	g IDT	
	and 4/4, on the ever	ning shift on 3/18 and 4/15, and		meetings to ensure the resid	dents	
	on the night shift or	n 4/9/2023.		are both receiving care per	MD	
				orders and that it is docume	nted	
	The MAR indicated	d Resident B was to have his		correctly.		
	, ,	nged every 3 days. The MAR		·All residents with colostor	mies	
	indicated the reside care on 3/4, 3/10, 3	ent was not given colostomy		will receive care as ordered.		
	Suic on 5/7, 5/10, 5	. 17 and 11312023.		How the corrective action w	ill he	
	During an interview	w, on 5/8/2023 at 1:20 p.m., with		monitored to ensure the def		
	_	cal Staff (RCS), DON and		practice will not recur, what		
	_	RCS indicated the MARs had		assurance program will be p		
		ed correctly. He was not aware		place:	at into	
		atments had been performed or		·The unit managers will pe	erform	
		d. The staff were to document		MAR/TAR audits during each		
	_	hich had been completed per		morning IDT meeting as a		
	the physician's orde			standard practice to ensure	that	
	physician's orde			care is both provided as ord		
	A current facility p	olicy, titled "Abuse Prevention		and documented as require		
				, sind documentou do require		

Program," dated as last revised March 2021 and

received from the Executive Director on 5/4/23 at

1:55 p.m., indicated "...Neglect is the failure of the

·The nurse managers will audit

catheters during IDT rounds daily

for 60 days and then weekly for 60

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

PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243  NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905			ETED		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR facility, its employe provide goods and s necessary to avoid p anguish or mental il	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION  Sees or service providers to service to a resident that are ohysical harm, pain, mental lness"  ates to Complaint IN00406869.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  days and monthly for 60 days. Nurse managers will ensure th colostomy bags are emptied e shift, that the colostomy applia is changed every three days w an appropriate date, and that ostomy care is completed per orders. Results will be shared in QA meeting monthly.	nat ach ince vith	(X5) COMPLETION DATE

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