STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 00 B. WING	05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00406869, IN00405075 and IN00406151. Complaint IN00406869 - Federal/state deficiencies related to the allegations are cited at F684, F690 and F691. Complaint IN00405075 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00406151 - No deficiencies related to the allegations are cited. Survey dates: May 3, 4, 5 and 8, 2023 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 5 Medicaid: 89 Other: 4 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 16, 2023.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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

Emily D Cook | 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.

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to provide wound treatment and wound interventions as ordered by the physician for 2 of 3 residents reviewed for quality of care. (Residents D and B) Findings include: 1. The record for Resident D was reviewed on 5/5/2023 at 1:55 p.m. Diagnoses included, but were not limited to, non-pressure chronic ulcer of unspecified part of left lower leg (LLL) with fat layer exposed, congestive heart failure, peripheral chronic venous insufficiency, type 2 diabetes mellitus, atrial fibrillation, localized edema, and chronic embolism and thrombosis of unspecified vein. An admission Minimum Data Set (MDS) assessment, dated 2/28/23, indicated the resident had one venous and arterial ulcer and required extensive assist of 1 person for personal hygiene. A care plan indicated Resident D had symptoms of cellulitis. Interventions included, but were not limited to, observe for edema, observe for signs of infection, and treatment as ordered. The Medication Administration Record (MAR) indicated Resident D was to receive LLL treatment, to cleanse with normal saline, pat dry,	F 0684	Deficiency ID: F 684: Quality of Care Completion Date: 5/24/23 Plan of Correction: What corrective action will be accomplished for those residents found to have been affected by the deficient practice: · Resident D had wound treatment to the LLL. MAR indicated that the treatment was not completed on 3/20/23. A note from the wound care center on 3/23/23 indicated the resident was sent to the hospital for evaluation. · Resident B had two stage 2 pressure ulcers which were present upon admission and was to receive sacrum wound care daily. The MAR indicated that the resident had not received wound treatment to his sacrum on 3/11, 3/12, 3/27 and 3/29. · Resident B was to receive wound care to his left calf and the MAR indicated this care was not given on 3/11, 3/12, 3/19, 3/26, 3/27, and 4/3. · Resident B was to receive Dakin's (1/2 strength) to the sacrum and left calf and the MAR	05/24/2023

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	apply calcium and alginate to the wound, and to apply zinc oxide to the peri wound. Cover the wound with super absorbent dressing. Cover both legs with 3-layer compression wraps. Change the dressing every Monday on the day shift related to the non-pressure chronic ulcer of the unspecified part of the LLL with fat exposed. The MAR indicated the treatment was not completed on 3/20/2023. A note from the wound care center, on 3/23/2023, indicated the resident was sent to the hospital for evaluation of possible cellulitis. During an interview, on 5/8/2023 at 1:16 p.m., with the Regional Clinical Staff (RCS), DON and Wound Nurse, the RCS indicated the treatment had not been documented as completed. Staff were not aware of the possible cellulitis until the notification, on 3/23/2023, the resident had been sent to the hospital for further evaluation from the wound clinic. 2. The record for Resident B was reviewed on 5/4/2023 at 1:03 p.m. Diagnoses included, but were not limited to, acquired absence of right upper limb below the elbow, pressure ulcer sacral region - stage 4, cardiomyopathy, flaccid neuropathic bladder, colostomy status, other disorders of the circulatory system, peripheral vascular disease, and venous insufficiency. An annual Minimum Data Set (MDS) assessment, dated 3/17/23, indicated the resident was an extensive 2 person assist for toileting, an extensive 1 person assist for personal hygiene, and had two stage 2 pressure ulcers which were present on admission. A care plan indicated Resident B had impaired		indicated this treatment was not completed on the day shift on 3/11, 3/12, 3/26, and 3/27. · Resident B was to receive betadine to right heel and the MAR indicated the resident was not given the wound care on 3/11, 3/12, 3/19, 3/26, 3/27 · Resident B was to receive barrier cream to the buttocks daily and the MAR indicated the resident was not given the treatment on ¾, 3/11, 3/12, 3/19, 3/27, and 4/4. · Resident B was to receive dry absorbent pad to the groin and the MAR indicated this treatment was not received on 3/11, 3/12, 4/3, and 4/4. · Resident B was to receive sacral cleanse and treatment and the MAR indicated this was not given on 4/4. · Resident B was to have pressure reduction boots at all times while in bed. The MAR indicated that the resident was not checked to have the pressure boots on 3/4, 3/11, 3/12, 3/19, 4/3, and 4/4 and on the evening shift of 3/18 and 4/15, and on the night shift on 4/9. · Resident B was to receive monitoring and adjustment of the low airloss mattress. The MAR indicated that this was not given on dayshift on ¾, 3/11, 3/12, 3/19, 4/3, 4/4, on the evening shift on 4/15, and on the night shift on 4/9. · There was no harm to either	

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	skin integrity to the buttocks related to moisture associated skin damage. Interventions included, but were not limited to, assess and document skin condition, and wound treatment as ordered. A care plan indicated Resident B had impaired skin integrity to the left calf related to a venous/stasis ulcer. Interventions included, but were not limited to, assess and document skin condition, and wound treatment as ordered. A care plan indicated Resident B had impaired skin integrity related to a right heel pressure ulcer. Interventions included, but were not limited to, assess and document skin condition, and wound treatment as ordered. A care plan indicated Resident B had impaired skin integrity related to a sacrum pressure ulcer. Interventions included, but were not limited to, assess and document skin condition, and wound treatment as ordered. A care plan indicated Resident B had symptoms of a wound infection. Interventions included, but were not limited to, notify MD of worsening or unchanged condition, document abnormal findings, and treatment as ordered. The MAR indicated Resident B was to receive sacrum wound care daily, and to cleanse with Dakin's, apply calcium alginate with silver and moistened Dakin's gauze to the wound bed, and to cover with an adsorbent dressing. Apply zinc ointment to the Moisture-Associated Skin Damage (MASD). The MAR indicated the resident was not given the wound care on 3/11, 3/12, 3/27 and 3/29/2023. The MAR indicated Resident B was to receive		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. · All Residents with wound care orders or wound care prevention orders have the potential to be affected. · The wound care nurse will round on all new admissions and readmissions prior to the next morning IDT and performs a head to toe assessment in order to identify residents will community acquired wounds and to assess for the risk of skin breakdown. The wound care nurse updates care plan and floor nurse of any needed interventions to prevent skin breakdown. · Monthly skin sweeps are performed by nurse leaders · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur · Education has been provided to all nurses including wound care policy, wound care procedures and skin management. · Unit managers are performing MAR/TAR audits daily during IDT meetings to ensure the residents are both receiving care per MD orders and that it is documented correctly. · Nurse managers will audit	

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	wound care to his left calf, to cleanse with wound cleanser, pat dry, apply calcium alginate to the wound and to cover with super absorbent dressing, roll gauze, and stretchnet. Change daily. The MAR indicated the resident was not given the wound care on 3/11, 3/12, 3/19, 3/26, 3/27 and 4/3/2023. The MAR indicated Resident B was to receive Dakin's (1/2 strength) solution 0.25% (sodium hypochlorite), to apply to the sacrum and left calf topically every dayshift. The MAR indicated the treatment was not completed on the dayshift on 3/11, 3/12, 3/26, and 3/27/2023. The MAR indicated Resident B was to receive betadine external solution, to apply to the right heel topically every dayshift. Cleanse with wound cleanser, apply skin prep to the peri-wound, apply betadine moistened gauze, and change daily. The MAR indicated the resident was not given the wound care on 3/11, 3/12, 3/19, 3/26, 3/27 and 4/4/2023. The MAR indicated Resident B was to receive Cavilon Durable Barrier external cream 1.3%, to apply to the buttocks topically every day. The MAR indicated the resident was not given the care on 3/4, 3/11, 3/12, 3/19, 3/27 and 4/4/2023. The MAR indicated Resident B was to receive + dry absorbent pad or equivalent to the left groin/scrotum skin to manage moisture once a day. The MAR indicated the resident was not given the care on 3/11, 3/12, 4/3 and 4/4/2023. The MAR indicated Resident B was to receive a sacrum cleanse with wound cleanser. To apply hydrofera blue to the wound bed, cover with an absorbent dressing, and to apply zinc ointment to		wound treatments during IDT rounds to ensure that the wound treatment was completed and dated with the correct date. · Nurse managers will audit care plans during IDT meetings to ensure that each wound and intervention is care planned. · Nurse managers will audit wound interventions daily during IDT rounds. · All residents with wound care orders will receive wound care as ordered. · How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: · The nurse managers will audit wound care treatments for correct dates, presence of interventions five days a week for 60 days, weekly for 60 days, and monthly for 60 days. · Review each month in QAPI.	

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	the MASD. The MAR indicated the resident was not given the wound care on 4/4/2023. The MAR indicated Resident B was to have pressure reduction boots on at all times while in bed. The MAR indicated the resident was not checked to have the pressure reduction boots on the dayshift on 3/4, 3/11, 3/12, 3/19 4/3 and 4/4, on the evening shift on 3/18 and 4/15, and on the night shift on 4/9/2023. The MAR indicated Resident B was to receive monitoring and adjustment of the low air loss mattress with settings per the resident's weight. The MAR indicated the resident was not given the care on the dayshift on 3/4, 3/11, 3/12, 3/19, 4/3 and 4/4, on the evening shift on 4/15, and on the nightshift on 4/9/2023. A nursing note, dated 4/18/2023, indicated the resident was sent to the hospital for evaluation when his scrotum area appeared edematous and had a greenish/black area to the right side of his penis shaft. A hospitalization note, dated 4/15/2023, indicated the resident was admitted for a diagnosis of Fournier's gangrene of penile and scrotal area. During an interview, on 5/8/2023 at 1:20 p.m., with the Regional Clinical Staff (RCS), DON and Wound Nurse, the RCS indicated the treatment had not been documented as completed. The MARs had not been documented correctly. He was not aware if the resident treatments had been performed or not been performed. The staff were to document every procedure which had been completed per the physician's order. A current facility policy, titled "Abuse Prevention			

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	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 facility, its employees or service providers to provide goods and service to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness...." A current facility policy, titled "Skin Management," dated October 2019 and received from the Executive 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...." This Federal tag relates to Complaints IN00406869 and IN00405075. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an			

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	indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to provide Foley catheter care as ordered by the physician for 1 of 3 residents reviewed for catheter care. (Resident B) Finding includes: The record for Resident B was reviewed on 5/4/2023 at 1:03 p.m. Diagnoses included, but were not limited to, acquired absence of right upper limb below the elbow, cardiomyopathy, flaccid neuropathic bladder, colostomy status, other disorders of the circulatory system, peripheral vascular disease, and venous insufficiency. An annual Minimum Data Set (MDS) assessment, dated 3/17/23, indicated the resident was an extensive 2 person assist for toileting, an extensive 1 person assist for personal hygiene, and had an indwelling catheter. A care plan indicated Resident B was at risk for infection/complications related to an indwelling	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 residents found to have been affected by the deficient practice: · Resident B was found to have not had documented foley catheter care, foley catheter flush with acetic acid, or a privacy bag for the foley catheter over several 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. · Residents will be identified	05/24/2023

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	catheter and neurogenic bladder. Interventions included, but were not limited to, document catheter output every shift, catheter and peri-care at least every shift and as needed and keep drainage bag and tubing below the level of the bladder. The Medication Administration Record (MAR) indicated Resident B was to have the Foley catheter urinary drainage bag covered for privacy on every shift. The MAR indicated this was not completed on the day shift on 3/4, 3/11, 3/12, 3/19, 4/3 and 4/4, on the evening shift on 3/18/2023 and 4/15, and on the night shift on 4/9/2023. The MAR indicated Resident B was to receive Foley catheter care on every shift. The MAR indicated the resident did not receive Foley catheter care on the day shift on 3/4, 3/11, 3/12, 3/19, 4/3 and 4/4, on the evening shift 3/18 and 4/15, and on the night shift on 4/9/2023. The MAR indicated Resident B was to have the Foley catheter irrigated with 60 ml (milliliters) of acetic acid daily. The MAR indicated the resident was not given this irrigation on 3/4/2023. The MAR indicated Resident B was to receive acetic acid solution 5%, to insert 60 cc in the urethra every day. The MAR indicated the resident was not given this care on 3/4, 3/11, 3/12, 3/19, 3/26, 3/27, 3/28, 4/3, and 4/4/2023. During an interview, on 5/8/2023 at 1:20 p.m., with the Regional Clinical Staff (RCS), DON and Wound Nurse, the RCS indicated the MAR had not been documented correctly. He was not aware if the resident's treatments had been performed or not been performed. The staff were to document every procedure which had been completed per		by most recent MDS. · All new residents and readmissions will be reviewed in IDT meeting for foley catheters or other urinary devices. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur · Education has been provided to all nurses including the policy on foley catheter care. · Unit managers are performing MAR/TAR audits daily during IDT meetings to ensure the residents are both receiving care per MD orders and that it is documented correctly. · All residents with foley catheters will receive care as ordered. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: · The unit managers will perform MAR/TAR audits during each morning IDT meeting as a standard practice to ensure that care is both provided as ordered and documented as required. · The nurse managers will audit catheters during IDT rounds daily for 60 days and then weekly for 60 days and monthly for 60 days. Catheter care will be audited by observing for catheter tubing secured and not kinked with an unobstructed flow, output reported	

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	physician's order. A current facility policy, titled "Abuse Prevention 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 facility, its employees or service providers to provide goods and service to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness...." This Federal tag relates to Complaint IN00406869. 3.1-41(a)(1)		each shift, that the bag is kept below bladder level, tubing and bag are not in contact with the floor and a basin is in place if the resident is in a low bed, a privacy bag is being utilized, and that catheter care is performed each shift. ·Results will be shared in QAPI meeting monthly.	
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to provide colostomy care as order by the physician for 1 of 3 residents reviewed for colostomy care. (Residents B) Findings include: The record for Resident B was reviewed on 5/4/2023 at 1:03 p.m. Diagnoses included, but were not limited to, acquired absence of right upper limb below the elbow, pressure ulcer sacral region - stage 4, cardiomyopathy, flaccid neuropathic bladder, colostomy status, other disorders of the circulatory system, peripheral vascular disease, and venous insufficiency.	F 0691	Deficiency ID: F 691: Colostomy, Urostomy, or Ileostomy care Completion Date: 5/24/23 Plan of Correction: What corrective action will be accomplished for those residents found to have been affected by the deficient practice: ·Resident B was found to have not had documented colostomy care every shift as needed. ·There was no harm to the resident. How other residents having the	05/24/2023

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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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	An annual Minimum Data Set (MDS) assessment, dated 3/17/23, indicated the resident was an extensive 2 person assist for toileting, an extensive 1 person assist for personal hygiene, and had a colostomy. A care plan indicated Resident B had an alteration in gastrointestinal status related to a colostomy for a perforation of the intestine and a history of a fistula of the intestine. Interventions included, but were not limited to, colostomy care as ordered and as needed. The Medication Administration Record (MAR) indicated Resident B was to receive colostomy care every shift and as needed. The MAR indicated the resident was not given colostomy care on the day shift on 3/4, 3/11, 3/12, 3/19, 4/3 and 4/4, on the evening shift on 3/18 and 4/15, and on the night shift on 4/9/2023. The MAR indicated Resident B was to have his colostomy bag changed every 3 days. The MAR indicated the resident was not given colostomy care on 3/4, 3/10, 3/19 and 4/3/2023. During an interview, on 5/8/2023 at 1:20 p.m., with the Regional Clinical Staff (RCS), DON and Wound Nurse, the RCS indicated the MARs had not been documented correctly. He was not aware if the resident's treatments had been performed or not been performed. The staff were to document every procedure which had been completed per the physician's orders. A current facility policy, titled "Abuse Prevention 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		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ·Residents will be identified by most recent MDS. ·All new residents and readmissions will be reviewed in IDT meeting for bowel devices. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur: ·Education has been provided to all nurses including the policy of colostomy care. ·Unit managers are performing MAR/TAR audits daily during IDT meetings to ensure the residents are both receiving care per MD orders and that it is documented correctly. ·All residents with colostomies will receive care as ordered. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: ·The unit managers will perform MAR/TAR audits during each morning IDT meeting as a standard practice to ensure that care is both provided as ordered and documented as required. ·The nurse managers will audit catheters during IDT rounds daily for 60 days and then weekly for 60	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 00 B. WING	05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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	facility, its employees or service providers to provide goods and service to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness...." This Federal tag relates to Complaint IN00406869. 3.1-47(a)(3)		days and monthly for 60 days. Nurse managers will ensure that colostomy bags are emptied each shift, that the colostomy appliance is changed every three days with an appropriate date, and that ostomy care is completed per orders. ·Results will be shared in QAPI meeting monthly.	