STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00404161 and Complaint IN00404059. Complaint IN00404161-Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00404059-No deficiencies related to the allegations are cited. Survey dates: April 24, 25, 26, 27, & 28 2023 Facility number: 000477 Provider number: 155570 AIM number: 100290860 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 3 Medicaid: 21 Other: 13 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 4, 2023	F 0000	We respectfully request that this plan of correction be considered for a desk review in lieu of a post survey revisit. Thank you.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from			

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

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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	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse inflicted by another resident. This affected 1 of 4 residents reviewed for abuse. (Resident 12) Findings include: During an interview, on 4/25/23 at 10:47 a.m., Resident 12 indicated another resident hit him with his wheel chair, slapped him several times in the face, and his lip had bled. He said he was two or three doors down from his room at that time, and the resident who slapped him lives next door. An incident report was provided by the Executive Director, on 4/26/23 at 11:00 a.m. The incident report indicated on 3/26/23 at 2:45 p.m., Resident 23 and Resident 12 "were passing each other in the hallway when [Resident 23] stood up and made contact with [Resident 12]. Nursing staff intervened and assisted [Resident 23] away from [Resident 12]. Type of injury...Head to toe assessment completed with noted swelling to left side of [Resident 12's] face. Action taken - Residents were immediately separated. Resident	F 0600	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 12 was assessed per Licensed Nurse with no negative outcomes. Resident #23 was assessed per MD and Psych Services with new orders obtained, care plans updated with appropriate interventions as indicated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents were assessed for signs and symptoms of abuse with no negative outcomes. **What measures will be put into place and what systemic**	05/09/2023

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	[12] not in any psychosocial distress. 15-minute checks initiated. MD and responsible parties notified. Preventative measures taken - Residents do not reside in the same room. Psych services to follow up. Care plan will be reviewed for appropriate behavior management interventions. Any pertinent information will be added to follow up. Follow up - 3/31/2023 Residents seen by social services. Resident [12] not in psychosocial distress. Resident [23] seen by mental health services and new orders received. Facility will continue to follow orders. No further incidents." Resident 12's record was reviewed, on 4/26/23 at 12:04 p.m., and indicated diagnoses that included, but were not limited to, encephalopathy (altered brain function), alcohol use with alcohol - induced persisting dementia, chronic obstructive pulmonary disease, high blood pressure, age-related physical debility, repeated falls, and sleep disorders. An Admission Minimum Data Set assessment, dated 3/20/23 indicated Resident 12 was moderately cognitively impaired in cognitive skills for daily decision making, had behavioral symptoms directed towards others, behavioral symptoms not directed toward others, and these behaviors did not put the resident at significant risk for physical illness or injury, or interfere with the resident's care, or interfere with the resident's participation in activities or social interactions. This did not put others at significant risk of physical injury, intrude on the privacy or activity of others, or disrupt care or living environment. He wandered 1 to 3 days, which did not intrude on others. A progress note, dated 3/26/2023 at 2:45 p.m., indicated: "Resident passing another resident in		**changes will be made to ensure that the deficient practice does not recur;** All staff was educated on abuse and neglect on 5/9/2023 by the Executive Director/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for Abuse will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	hall other resident made inappropriate contact with resident, DON (Director of Nursing) and administrator notified." A progress note, dated 3/26/2023 at 2:45 p.m., indicated: "Late Entry: Note Text: Slight swelling noted to left side of face, no discoloration or open areas noted. NP/family notified." A progress note, dated 3/26/2023 at 3:41 p.m., indicated: "Social Services Note Late Entry: Resident walking down the hallway when other resident made inappropriate contact. Resident was assisted to hos (sic) room. Writer checked on resident later and he was resting in bed watching TV." An Interdisciplinary Team (IDT) progress note, dated 3/27/2023 at 9:36 a.m., indicated: "Late Entry: IDT met to review incident from 3/26/23. Resident was walking in hallway and another resident made inappropriate contact with resident. Slight swelling noted to left side of face at time of incident. No swelling noted today. Residents were immediately separated and skin assessment completed. NP and family notified of incident. Resident is pleasant this AM." Focused Charting, dated 3/27/2023 at 10:20 a.m., and 3/30/23 at 7:01 p.m., indicated Resident 12's vital signs were within normal limits, he had no signs or symptoms of psychosocial distress, and he was in a pleasant mood. During every day of the survey, Resident 12 was observed frequently walking in the hallway, he spoke to others, and was calm and friendly. During an interview, on 4/28/23 at 10:03 a.m., the Executive Director indicated Resident 23, has not			

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	been aggressive with any other residents and they placed him in a room by himself so he would be away from residents. A policy for "Abuse Prevention Program", with a last revision date of March, 2021, was provided by the Executive Director, on 4/26/23 at 11:25 a.m. The policy included, but was not limited to: "Policy: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom...Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents...To help with identification of incidents of abuse, the following definitions of abuse are provided: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...." 3.1-27(a)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide dependent residents with nail care, oral care, hair care and facial hair removal for 3 of 7 residents reviewed for Activities of Daily Living (ADL) (Resident C, Resident E and Resident G). Findings include:	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Nail care was provided to resident C on 5/1/2023. Oral care was provided to resident	05/09/2023

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	1.) During an observation on 4/24/23 at 2:21 p.m., Resident C's fingernails were long with black substance underneath them. During an interview with Resident C's family member on 4/25/23 at 1:35 p.m., indicated the resident's teeth had gotten worse since being at facility. The family member indicated she was unsure if the facility was providing the resident with oral care because she had never seen a toothbrush or toothpaste in the resident's room. During an observation on 4/25/23 at 2:01 p.m., Resident C's fingernails were long with black substance underneath them. During an observation on 4/26/23 at 12:05 p.m., Resident C was sitting in the dining room in a wheelchair, the resident's fingernails were long with black substance underneath them. The resident's teeth had a thick film on them with white substance at gum line, the resident had mouth odor when she talked. The resident indicated the staff do not assist her with brushing her teeth and she wouldn't mind if they would help her brush her teeth. The resident indicated she did not necessarily like her fingernails long like they were. Review of the record of Resident C on 4/26/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, psychosis, schizophrenia, degenerative disease, hypertension, depression, obsessive compulsive disorder, peripheral vascular disease, pressure ulcer of the left heel and chronic kidney disease. The plan of care for Resident C, dated 12/29/23, indicated the resident was at risk for oral/dental problems due to missing teeth. The interventions		C on 4/29/2023. Hair Care was provided to resident E on 5/3/2023. Personal care/shaving was provided to resident G on 4/29/2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficiency. An all-staff in-service was conducted on 5/9/2023 by the Executive Director/designee addressing the proper care of nails, teeth, hair, and facial hair including resident preference. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The IDT will round daily, 5 days per week, to ensure proper ADL care is completed. Any deficient practice will be reported to the Executive Director for correction. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for ADL care will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100%	

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	included, but were not limited to, provide mouth care or encourage resident to perform oral care twice daily and as needed and provide nail care on bath days. The Quarterly Minimum Data Set (MDS) for Resident C, dated 4/7/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of one person for personal hygiene. During an observation on 4/27/23 at 11:55 a.m., LPN 4 searched Resident C drawers and bedside table there was no toothbrush or toothpaste. The resident's bathroom there was no toothbrush or toothpaste observed. During an interview with the Director Of Nursing on 4/27/23 at 2:15 p.m., indicated it was the CNA's responsibility to provide Resident C with nail care and it was the nurses and CNA's responsibility to provide Resident C with oral care. 2. The clinical record for Resident E was reviewed on 4/26/2023 at 1:30 p.m. The medical diagnoses included apraxia and stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 22/3/2023, indicated that Resident E needed assistance of one staff for her bathing tasks. A care plan, dated 10/29/2022, indicated Resident E was dependent on one or two staff members for bathing tasks. An interview with Resident E and observation on 4/24/2023 at 2:44 p.m. indicated resident had greasy hair. Resident E stated she had only two showers and two baths since she had been in the facility. She stated they do not wash her hair.		threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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An observation on 4/25/2023 at 1:35 p.m. indicated Resident E was sitting in her wheelchair with her husband present, her hair remained greasy and appeared unkempt.

An observation on 4/26/2023 at 11:45 a.m., indicated Resident E's hair remained greasy and unkempt.

3. The clinical record for Resident G was reviewed on 4/26/2023 at 10:45 a.m. The medical diagnoses included dementia and difficulty walking.

An Annual MDS Assessment, dated 3/14/2023, indicated Resident G was cognitively intact and needed extensive assistance of one staff member for personal hygiene.

A care plan, dated 3/25/2022, indicated the Resident G needed staff assistance with grooming tasks.

An interview with Resident G and observation on 4/24/2023, indicated that Resident G had long facial hair on her chin. She indicated that staff only shave it on shower days and that the facial hair bother her. Resident G was pull at the hair on her chin during the conversation.

An observation on 4/25/2023 at 11:35 a.m. indicated Resident G continued to have long facial hair.

An observation on 4/26/2023 at 11:15 a.m. indicated Resident G continued to have long facial hair.

A policy entitled, "Activities of Daily Living (ADLs)," was provided by the Executive Director

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	on 4/27/2023 at 3:00 p.m. The policy indicated, " ...Care and services will be provided ...Bathing, dressing, grooming, and oral care ..." A policy entitled, "Grooming a Resident's Facial Hair," was provided by the Executive Director on 4/27/2023 at 3:00 p.m. The policy indicated, " ...It is the practice of this facility to assist resident with grooming facial hair ..." This Federal tag relates to Complaint IN00404161. 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care 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 observation, interview and record review the facility failed to provide pressure relieving boots for a resident with a heel wound and failed to timely identify and document a skin alteration for 2 of 3 residents reviewed for skin impairment (Resident C and Resident 5). Findings include: 1.) During an observation on 4/24/23 at 2:20 p.m., Resident C was laying in bed, the resident's heels were flat on the bed. The resident's pressure	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Director of Nursing/designee reviewed the plan of care for wound with all nursing staff for Resident C on 4/29/2023 and pressure relieving boots were applied. Resident C's heel wounds were assessed with no	05/16/2023

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	relieving boots were laying in her recliner. During an interview with Resident C's family member on 4/25/23 at 1:43 p.m., indicated the resident did not always have her pressure relieving boots on when the family visited her. Review of the record of Resident C on 4/26/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, psychosis, schizophrenia, degenerative disease, hypertension, depression, obsessive compulsive disorder, peripheral vascular disease, pressure ulcer of the left heel and chronic kidney disease. The physician order for Resident C, dated 3/4/23, indicated the resident was ordered pressure relieving boots to bilateral feet every shift. The wound assessment for Resident C, dated 3/3/23, indicated the resident acquired an unstageable pressure ulcer to the left heel measuring 5.18 centimeter (cm) by 4.71 cm. The wound assessment indicated the resident was to have soft offloading heel boots. The wound assessment for Resident C, dated 4/7/23, indicated the resident had a arterial wound on the left heel measuring 6.63 cm by 6.27 cm. The area was dry and unstable with eschar. The wound changed from a pressure ulcer to a arterial wound related to vascular studies concluding extensive stenosis and calcification of the left arteries. The wound assessment indicated the resident was to have soft offloading heel boots. The plan of care for Resident C,dated 3/20/23, indicated the resident had developed a arterial ulcer to the left heel due to extensive stenosis and calcification of the left arteries and peripheral		negative outcome. Resident 5's wounds were assessed, correctly identified, documented and appropriate interventions are in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. A facility wide skin sweep was completed on 5/16/2023 by the DNS/Designee. All areas were properly identified and documented. Facility wide chart review was completed for all residents with wounds on 5/16/2023 by Director of Nursing/Designee. All wound interventions are present on care plan and in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on wound care, documentation, and interventions on 5/9/2023 by DNS/Designee. All nursing staff was educated on appropriate documentation implementation on identification of new skin impairment by Director of Nursing/designee on 5/9/2023. **How the corrective action(s) will be monitored to ensure the**	

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	vascular disease. The interventions included, but were not limited to, pressure relieving boots to bilateral feet daily. The Quarterly Minimum Data Set (MDS) for Resident C, dated 4/7/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of two people for bed mobility and transfers. The resident does not ambulate. The resident was at risk for pressure. The skin risk assessment for Resident C, dated 4/25/23, indicated the resident was at risk for developing a pressure ulcer. During an observation on 4/27/23 at 11:55 a.m., LPN 4 provided Resident C with a wound treatment to the left heel. The left heel was black and tender to touch. During an interview with the Director Of Nursing (DON) on 4/27/23 at 2:15 p.m., indicated it was the CNA's and nurses responsibility to ensure Resident C had on pressure relieving boots. 2. The clinical record for Resident 5 was reviewed on 4/27/2023 at 10:45 a.m. The medical diagnoses included Alzheimer's and diabetes. A Quarterly Minimum Data Set Assessment, dated 3/11/2023, indicated that Resident 5 was cognitively impaired. A skin impairment care plan, dated 11/3/2022, indicated Resident 5 had skin alternations to the right first and second toe related to dragging foot while in wheelchair. A weekly nursing assessment, dated 10/27/2022, indicated Resident 5 did not have any skin		**deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for wound management will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	alternations. A physician order for Resident 5, dated 10/30/2022, indicated a treatment for the right foot. No documentation indicated what kind of skin alternation identified for the treatment ordered on 10/30/2022. A nurse practitioner notes, dated 11/1/2022, indicated to send Resident 5 to the emergency room related to declining wounds to his feet. An after-visit summary from the hospital, dated 11/1/2022, indicated Resident 5 refused treatment (labs, intravenous fluids, and imaging) and left against medical advice. An observation on 4/25/2023 at 2:02 p.m., indicated Resident 5 was laying in bed with pressure reliving boots on. Resident 5's right foot had blackened toes. An interview with LPN 2 on 4/26/2023 at 1:35 p.m., indicated that Resident 5's foot started as a blister and was sheared open within days. He was taken to the emergency room but refused all treatment. He had a follow up appointment but refused to go. She indicated he has good and bad days, but he still routinely refuses cares. She stated Resident 5 will often kick during wound care and hit/pinch during other care, so she tries to reapproach him frequently. An interview with CNA 3 on 4/27/2023 at 2:25 p.m. indicated that they were aware of Resident 5's foot. Resident 5 was prone to refusals of care, including removing his shoes, prior to the discovery of the alternation. Since then, he does not wear shoes, but he does have the soft boots			

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	155570	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

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	he wears when he is in bed. They indicated that Resident 5's wound appeared very quickly as a blister and then it had busted open, but they could not remember the exact date of this. An interview with DON on 4/27/2023 at 1:30 p.m., indicated she was not the DON at the time of the incident with Resident 5's foot, but it reported that the alternation started as a blister related to the way he would self-propel in the wheelchair and occasionally drag his foot. At this time, he had a history of refusing care (taking off his shoes, getting in the shower, etc.). She stated Resident 5 was evaluated at the hospital on 11/1/2022 related to the skin shearing off the blister where he has refused treatment and came back to the facility. The progression of the wound was rapid. Since that time, a rounding wound care nurse practitioner has weekly seen him. An interview with DON on 4/27/2023 at 2:05 p.m. indicated she could not locate documentation related to the initial identification of the skin impairment to Resident 5's foot impairment. A policy entitled, "Skin Management," was provided by the Director of Nursing on 4/27/2023 at 10:30 a.m. The policy indicated, " ...Alternations in skin integrity will be reported to the physician/NP and responsible party/family ...All newly identified areas after admission will be documented ...IDT [Interdisciplinary] review of new skin alternations in skin integrity will be completed weekly ..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to assist a resident while in the bathroom resulting in a fall and failed to implement a fall intervention of a mat beside the bed for 2 of 6 residents reviewed for accidents (Resident C and Resident 5). Findings include: 1.) During an interview with Resident C's family member on 4/25/23 at 1:44 p.m., indicated Resident C fell trying to go to the bathroom on her own a few weeks ago. Review of the record of Resident C on 4/26/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, psychosis, schizophrenia, degenerative disease, hypertension, depression, obsessive compulsive disorder, peripheral vascular disease, pressure ulcer of the left heel and chronic kidney disease. The plan of care for Resident C, dated 1/6/23, indicated the resident was at risk for falls due to weakness and an unsteady gait with a past of falls and attempts to transfer self. The interventions included, assist with toileting. The fall risk assessment for Resident C, dated 1/20/23, indicated the resident was at a high risk for falls.	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Director of Nursing/designee reviewed the plan of care for fall interventions with all staff involved in the care of Resident C on 5/9/2023. Fall interventions remain appropriate. Resident will not be left in bathroom alone. Director of Nursing/designee reviewed the plan of care for fall interventions with all staff involved in the care of Resident 5 on 5/9/2023. Fall Interventions remain appropriate. Fall mat was placed along side resident bed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficiency. An all-staff in-service was conducted on 5/9/2023 by the Executive Director/designee which addressed following fall	05/16/2023

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	The progress note for Resident C, dated 3/31/23 at 7:58 p.m., indicated the resident had an unwitnessed fall. The resident had no injuries and was assisted by two staff into the wheelchair. The Interdisciplinary Team (IDT) progress note for Resident C, dated 4/3/23, indicated the resident was found sitting on the floor in front of the toilet on 3/31/23. The resident had been sitting on the toilet prior to falling. The resident stated she was trying to go back to bed. The intervention was not to leave the resident alone in the bathroom. The Quarterly Minimum Data Set (MDS) for Resident C, dated 4/7/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of two people for transfers and toileting needs. The resident does not ambulate. The kardex for Resident C, dated 4/28/23, indicated the safety precautions, included, but were not limited to, do not leave alone in the bathroom. During an observation on 4/27/23 at 10:30 a.m., Physical Therapy Assistant (PTA) 9 and CNA 3 used a gait belt and transferred Resident C from the wheelchair to the toilet. She required extensive assist of 2 for the transfer. She kept her legs partially bent at the knees all the time. She was returned to her wheelchair with 2 assist and the gait belt. During an interview with the Director Of Nursing (DON) on 4/27/23 at 2:15 p.m., indicated Resident C was left alone in the bathroom on 3/31/23 when she fell. The CNA had left the Resident C alone in the bathroom to go get something. The DON		interventions for all residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Director of Nursing/designee completed chart audit for all falls in the last 30 days to ensure appropriate interventions are in place and present on care plan on 5/16/2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for Fall management will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	indicated she verbally communicates to staff not to leave residents alone in the bathroom and it was also communicated on Resident C's kardex. 2. The clinical record for Resident 5 was reviewed on 4/27/2023 at 10:45 a.m. The medical diagnoses included Alzheimer's and diabetes. A Quarterly Minimum Data Set Assessment, dated 3/11/2023, indicated that Resident 5 was cognitively impaired. A fall care plan, dated 4/11/2022, indicated for Resident 5 to have a low bed with a fall mat. An observation on 4/25/2023 at 2:02 p.m., indicated Resident 5 was laying in bed with his fall mat folded at the end of his bed. An observation on 4/26/2023 at 12:30 p.m., indicated Resident 5 was laying in bed with his fall mat folded at the end of his bed and stood upon edge. An observation on 4/26/2023 at 1:10 p.m. indicated Resident 5 was laying in bed with his fall mat folded at the end of his bed and stood upon edge. A policy entitled, "Fall Management," was provided by the Executive Director on 4/28/2023 at 10:25 a.m. The policy indicated, " ...A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors ..." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to notify Resident E's physician of a clinically significant weight loss for 1 of 2 resident reviewed for nutrition. (Resident E) Findings include: The clinical record for Resident E was reviewed on 4/26/2023 at 1:30 p.m. The medical diagnoses included apraxia and stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 22/3/2023, indicated that Resident E needed assistance of one staff for her bathing tasks. A nutritional care plan for Resident E, dated 11/1/2022, indicated for weights to be obtained as ordered and to notify the physician of significant	F 0692	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E's MD was notified of significant weight change on 12/8/22. This is documented in the weekly risk meeting note. The Director of Nursing and the Registered Dietician reassessed the nutritional status of Resident E on 5/9/2023. Revisions were made to the care plan and revised interventions were reviewed with staff involved in the care of Resident E. Resident E's weight was obtained on 5/4/2023. **How other residents having the potential to be affected by the**	05/09/2023

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	weight changes. Weights recorded for Resident E: 10/29/2022 - 184 lbs. (Admission) 11/4/2022 - 182 lbs. 12/6/2022 - 160 lbs. (-12.1% in one month) 1/6/2023 - 146 lbs. (-8.75% in one month) 2/6/2023 - 145 lbs. The clinical record did not indicate weekly weight for the first four weeks after admission and did not include weight weights after significant weight variation. No register dietician recommendations or visit completed after weight variation on 12/6/2023. An interview with DON on 4/27/2023 at 3:05 p.m. indicated she could not locate weekly weights after admission or after weight variation. A policy entitled, "Resident Weight Monitoring," was provided by the Executive Director on 4/28/2023 at 10:25 a.m. The policy indicated, " ...Weekly Weights ...should include new admissions ... [and] residents exhibiting significant weight changes ..." 3.1-46(a)(1)		**same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficiency. All nursing staff were inserviced on 5/9/2023 by the DNS/Designee on the weight management policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/designee and Registered Dietician will review each weight report to ensure appropriate measurements are recorded and to monitor significant weight changes and MD/NP notifications in significant weight changes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for Weight Monitoring will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to monitor the type of behaviors and interventions used after a behavior occurred for 1 of 4 residents reviewed for behaviors. (Resident 23) Findings include: Resident 23's record was reviewed, on 4/26/23 at 2:18 p.m., and indicated diagnosis that included, but were not limited to, epileptic seizures, high blood pressure, dementia, depression, anxiety, psychotic disorder with delusions, history of transient ischemic attacks and stroke, and repeated falls. An Admission Minimum Data Set (MDS) assessment, dated 6/1/22, indicated Resident 23 was cognitively intact, he had verbal behavioral symptoms directed toward others such as threatening others, screaming at others, and cursing at others, but did not put others at significant risk for physical injury. A Quarterly MDS, dated 3/20/23, indicated	F 0740	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #23's behavior management plan was updated with specific behaviors and interventions for staff to document on 4/28/23. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident's that exhibit behaviors have the potential to be affected by the alleged deficient practice. All staff were educated on 5/9/2023 by the Executive Director/Designee on the Behavior Management policy. **What measures will be put into place and what systemic changes will be made to**	05/09/2023

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	Resident 23 was moderately cognitively impaired, had behaviors of delusions, verbal behavioral symptoms directed toward others such as threatening others, screaming at others, cursing at others, and wandered 1 to 3 days during the 7 day assessment period. A care plan for: "[Resident 23] exhibits behavior symptoms of physical aggression towards others as dated 3/27/23. Goals: [Resident 23] will demonstrate the ability to seek out staff/caregiver support when feeling frustrated or provoked." Interventions included, but were not limited to, will demonstrate effective coping skills related to behavior, administer medications as ordered, allow resident to vent feelings and needs, approach resident in a calm and friendly manor, assess resident's needs for food, thirst, toileting, comfort level, body positioning, pain, and treat if indicated, document behaviors per behavior management program, identify behavior triggers and reduce exposure to triggers. On 4/26/23 at 10:25 a.m., Resident 23 was observed in bed, sitting up, with his eyes closed. On 4/26/23 at 1:05 p.m., Resident 23 was observed sitting up in bed, his overbed table was over his bed with his lunch on it. He was feeding himself and a few minutes later he was calling out "help". He has been observed to call for help and his call light was in reach. Behavior monitoring records for March and April 2023, were reviewed and indicated behaviors are documented on the Treatment Administration Record (TAR). The TAR for March 2023 indicated Resident 23 had 10 behaviors. The TAR for April 1 through April 27th, indicated Resident 23 had 7		**ensure that the deficient practice does not recur;** All behavior management plans were audited by DNS/Designee to ensure specific behaviors and interventions are in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for Behavior Management will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	behaviors. There was no documentation that indicated the type of behavior, nor what interventions were used to address the behavioral needs of the resident. On 4/28/23 at 1:00 p.m., the Director of Nursing indicated they did not document the type of behavior and she is going to reach out to their consultants for additional training; she thinks her staff needs more training. She said she added, on the CNA's tasks, a place for the CNA's to document behaviors. A policy for "Mood and Behavior Management" was provided by the Director of Nursing on 4/28/23 at 1:16 p.m. The policy included, but was not limited to: "Purpose: To provide interventions for residents exhibiting problematic or distressing moods and/or behaviors. Policy: It is the policy of Majestic Care to provide interventions for all residents with behavioral and/or mood indicators that may be problematic or distressing. Residents are provided a supportive environment that is aimed at preventions, relief and/or accommodation of their behavior and/or mood in addition to interventions that are specific to the resident's individualized needs. 3.1-43(a)(1)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review the facility	F 0745	What corrective action(s) will be	05/09/2023

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	failed to provide psychiatric services for a resident with mental illness for 1 of 1 resident reviewed for psychiatric services (Resident C). Finding include: During an interview with Resident C's family member on 4/25/23 at 1:48 p.m., indicated the resident had mental illness schizophrenia. The family member was concerned that she was not receiving the care and counseling she needed. The family member indicated Resident C had received psychiatric services most of her life and felt the resident would benefit from psychiatric services. Review of the record of Resident C on 4/26/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, depression, psychosis, schizophrenia and obsessive compulsive disorder. The pharmacy recommendations for Resident C, dated 1/17/23, indicated the resident was due for a gradual dose reduction on her antidepressant and antipsychotic medication. The physician responded to refer the resident to psychiatric services. The physician order for Resident C, dated 1/23/23, indicated the resident was ordered psychiatric services provided by the local long term care psychiatric elder care provider. The plan of care for Resident C, dated 3/2/23, indicated the resident was at risk for alteration in mood and depression symptoms because the resident had verbalized or displayed the following mood indicators: little pleasure/interest in doing things, feeling tired or having little energy and		accomplished for those residents found to have been affected by the deficient practice; Resident C has received a consult for psych services on 4/29/23. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with a mental illness have the potential to be affected by the alleged deficient practice. All residents with a mental illness diagnosis have been audited to ensure if appropriate a referral for psych services has been made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Social Services was educated by the Executive Director/DNS on psych services referrals on 5/9/2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool for Ancillary Services will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI	

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	trouble concentrating. The intervention included, but were not limited to, behavioral health consults as needed. The Quarterly Minimum Data Set (MDS) for Resident C, dated 4/7/23, indicated the resident was moderately impaired for daily decision making. The resident had depression, psychotic disorder and schizophrenia. During an interview with the Director Of Nursing (DON) on 4/27/23 at 2:15 p.m., indicated Resident C had not been treated by psychiatric services. The resident would be seen the next time psychiatric services came to the facility. The DON indicated it was the Social Service Director's responsibility to ensure Resident C had been seen and provided psychiatric services. The behavioral health services policy provided by the Administrator on 4/28/23 at 10:20 a.m., indicated the facility would provide and residents would receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being. 3.1-(a)(3)		committee during the monthly meeting.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

(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
	§483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, interview and record review the facility failed to provide routine dental services for residents with missing teeth and teeth that were in poor repair for 3 of 5 residents reviewed for dental services (Resident C, Resident	F 0791	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	05/09/2023

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	14 and Resident 21). Findings include: 1.) During an interview on 4/24/23 at 2:26 p.m., Resident C indicated her teeth were bad and she wanted them fixed. The resident would not show me her teeth because she said they were bad. During an interview with Resident C's family member on 4/25/23 at 1:35 p.m., indicated the resident's teeth had gotten worse since being at facility. The resident was missing teeth and had not been seen by a dentist. Review of the record of Resident C on 4/26/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, psychosis, schizophrenia, degenerative disease, hypertension, depression, obsessive compulsive disorder, peripheral vascular disease, pressure ulcer of the left heel and chronic kidney disease. The physician order for Resident C, dated 6/29/23, indicated the resident may receive dental services. 2.) During an observation and interview with Resident 14 on 4/25/23 at 12:09 p.m., indicated she did not have any mouth pain, but her upper dentures did not fit anymore. The resident indicated she would like to see a dentist and get new dentures but she had not. The resident was observed to have no upper teeth/dentures. Review of the record of Resident 14 on 4/28/23 at 12:20 p.m., indicated the resident's diagnoses, included but were not limited, chronic kidney disease, diabetes, dysphagia, chronic respiratory failure and asthma.		Social Service/Designee sent referral on Resident C for dental services on 4/27/2023. Resident C was assessed by licensed nurse and no negative outcomes noted. Social Service/Designee sent referral on Resident 14 for dental services on 4/27/2023. Resident 14 was assessed by licensed nurse and no negative outcomes noted. Social Service/Designee sent referral on Resident 21 for dental services on 4/27/2023. Resident 14 was assessed by licensed nurse and no negative outcomes noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficiency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Social Service Director/designee was educated by Executive Director on 5/9/2023. All new admissions to facility or any resident with any significant changes with oral care will be referred for dental services. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	The physician order for Resident 14, dated 12/16/22, indicated the resident may receive dental services. 3.) During an observation on 4/25/23 at 2:01 p.m., Resident 21 was missing several lower and upper teeth and teeth were in poor repair. Review of the record of Resident 21 on 4/26/23 at 2:32 p.m., indicated the resident's diagnoses included, but were not limited to, traumatic subdural hemorrhage, bipolar disorder and dementia. The physician order for Resident 21, dated 3/31/22, indicated the resident may receive dental services. During an interview with the Director Of Nursing (DON) on 4/27/23 at 2:15 p.m., indicated she could not find where Resident C, Resident 14 or Resident 21 had received dental services. The DON indicated it was the Social Service Director's responsibility to ensure the residents received dental services. The dental services policy provided by the Administrator on 4/28/23 at 10:20 a.m., indicated the facility would obtain needed dental services, including routine and emergency dental services and assist in providing these services and make prompt referrals for dental services. 3.1-24(a)(1)(b)		**recur, i.e., what quality assurance program will be put into place;** QAPI tool for Dental Services will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Social Service Director/designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	