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	09/12/2023

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00416164 and IN00416132. Complaint IN00416164 - Federal/state deficiencies related to the allegations are cited at F676 and F695. Complaint IN00416132- No deficiencies related to the allegations are cited. Survey dates: September 11 and 12, 2023 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 4 Medicaid: 79 Other: 5 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 20, 2023.	F 0000	This plan of correction serves as our credible allegation of compliance. Majestic Care of Lafayette requests desk compliance for this plan of correction.	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility			

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

Brian Lessley | Administrator | 10/06/2023

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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	must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on record review and interview, the facility failed to ensure residents were provided Activities of Daily Living (ADL) care for 4 of 4 residents reviewed for ADLs. (Residents J, K, L, and M)	F 0676	Deficiency ID F 676: Activities of Daily Living. what corrective action(s) will be accomplished for those residents found to have been	10/09/2023

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	Finding include: 1. An Indiana Department of Health (IDOH) reportable, dated 8/17/2023, indicated Resident J did not receive personal care when she needed to be changed on 8/16/2023. Resident B needed personal care when her ostomy bag leaked in her bed. She indicated CNA 2 did not provide her with care. CNA was terminated when the allegation was substantiated. The record for Resident J was reviewed on 9/12/2023 at 2:15 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, bipolar disorder, and hemiplegia. The resident had a Brief Interview for Mental Status (BIMS) of 14. This score indicated the resident was not cognitively impaired. During an interview, on 9/12/2023 at 3:50 p.m., Resident J indicated her ostomy bag had leaked in her bed and she called for assistance. CNA 2 came to assist her. CNA 2 she did not clean her bed or change her linen. She slept in a wet bed all night. She notified the nursing staff, on 8/17/2023, she had not received care on 8/16/2023 when her ostomy bag leaked all over her and her bed. CNA 2 put a clean sheet over her and walked out of the room and never returned. The resident slept and woke up wet and in a wet bed. 2. The record for Resident K was reviewed on 9/12/2023 at 3:10 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, type 2 diabetes mellitus, asthma, and edema. The resident had a BIMS score of 15. This score indicated the resident was not cognitively impaired.		affected by the deficient practice; Resident J had her colostomy bag changed, her linens changed, and her bed cleaned immediately upon receiving her complaint. CNA 2 was terminated due to lack of care for residents J, K, L and M and poor customer service. Resident K was provided care by CNA 2. CNA 2 was terminated due to lack of care for residents J, K, L and M and poor customer service. Resident L was unable to specify specific dates and times she did nor receive care from CNA 2. She was offered care at the time of interview, but did not require care at that time. CNA 2 was released from employment relating to the pattern of not providing care. CNA 2 was terminated due to lack of care for residents J, K, L and M and poor customer service. Resident M was assisted with care on 08/17 when she voiced her concern. CNA 2 was terminated due to lack of care for residents J, K, L and M and poor customer service. How other residents having the potential to be affected by the same deficient practice will be identified:	

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	During an interview, on 9/12/2023 at 3:57 p.m., Resident K indicated she had been turned on her side by CNA 2. She was in position to have herself cleaned by CNA 2. CNA 2 left her in that position. CNA 2 did not return for 2 hours to complete her care. Resident K did not report her incident until she was questioned by the staff regarding care by CNA 2 during an investigation. Resident K did not recall the date, she indicated CNA 2 left her many times in that position and did not return for a long time. 3. The record for Resident L was reviewed on 9/12/2023 at 3:20 p.m. Diagnoses included, but were not limited to, anxiety and depressive disorders, emphysema, and chronic obstructive pulmonary disease (COPD). The resident had a BIMS score of 15. This score indicated the resident was not cognitively impaired. During an interview, on 9/12/2023 at 4:02 p.m., Resident L indicated care had been started many times by CNA 2 and then she would leave and not come back. She indicated this had happened to her many times. Resident L did not report the incidents until she was questioned by the staff regarding care by CNA 2 during an investigation. Resident L did not recall the date. 4. The record for Resident M was reviewed on 9/12/2023 at 3:30 p.m. Diagnoses included, but were not limited to, COPD and type 2 diabetes mellitus. The resident had a BIMS score of 15. This score indicated the resident was not cognitively impaired.		All residents have the potential to be affected. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident interviews will be conducted weekly to determine of they are receiving assistance with needed ADL care. Those found not to be receiving ADL care when needed, will be provided assistance immediately if needed and an investigation may be performed to determine why the assistance was not provided. · CNA 2 was terminated prior to the survey due to lack of care to residents J, K, L and M and poor customer service. · CNA's will be inserviced on Activities of Daily Living · CNA's will be inserviced on Resident's Rights · CNA's will be inserviced on their job description. 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; The results of resident interviews will be reviewed daily in morning stand up meeting (m-f) and monthly in the QAA meeting for 6 months to ensure they are consistently done and all concerns addressed.	

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	A nursing note, dated 8/17/2023, indicated Resident M reported she was left with her pants and briefs around her knees on the side of her bed by CNA 2. CNA 2 just left the resident and the room and did not return. The resident wanted assistance from staff to complete dressing. During an interview, on 9/12/2023 at 4:40 p.m., the Executive Director (ED) indicated he interviewed CNA 2, and she denied the allegations of neglect of care. The ED suspended CNA 2 during the investigation. After the investigation was completed, the ED terminated CNA 2 due to lack of care to Residents J, K, L, and M and poor customer service. A policy was not received before the date of exit. This Federal tag relates to Complaint IN00416164. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C)		Exhibit B – Questionnaire, Exhibit C - Inservices	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to provide continuous oxygen flow for 2 of 2 residents reviewed for	F 0695	F695 what corrective action(s) will	10/09/2023

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	continuous oxygen per physician's orders at 2 liters. (Residents B and D) Findings include: 1. The record for Resident B was reviewed on 9/11/2023 at 4:05 p.m. Diagnoses included, but were not limited to, acute kidney failure, anemia, end stage renal disease, and hyperkalemia. The resident had a Brief Interview for Mental Status (BIMS) of 14. This score indicated the resident was not cognitively impaired. Nursing notes indicated Resident B had a physician's order, dated 8/16/2023, for oxygen at 2 liters per minute via nasal cannula continuous, may titrate as needed. During an interview, on 9/11/2023 at 4:01 p.m., Resident B was observed to have oxygen at 2 liters with continuous flow per nasal cannula while she was in bed in her room. She indicated she did not get continuous oxygen when she went to the dialysis center for her treatment. When she left her room, her oxygen was disconnected and then she was reconnected to oxygen when it was her turn in dialysis. The dialysis center was in the facility. Resident B indicated the same thing happened to her when she was done in dialysis and transported back to her room. She was disconnected from oxygen and was not reconnected to oxygen until she returned to her room. She could wait as long as 20 minutes without oxygen while waiting for staff to transport her to her room. The resident indicted she was worried sometimes; she was short of breath when she has had to wait over 10 minutes without oxygen.		be accomplished for those residents found to have been affected by the deficient practice; Resident B was connected to oxygen at 2 liters when transported to all future dialysis treatments and dialysis continues her oxygen when she enters the den and leaves the den. She is then transported back to her room with her oxygen still connected with no interruption in her oxygen. Resident D was connected to oxygen at 2 liters when transported to all future dialysis treatments and dialysis continues her oxygen when she enters the den and leaves the den. She is then transported back to her room with her oxygen still connected with no interruption in her oxygen. How other residents having the potential to be affected by the same deficient practice will be identified: Residents receiving dialysis orders will be audited in order to identify those that also have oxygen orders. Exhibit A – Audit tool All new orders for continuous flow oxygen for dialysis patients will be reviewed in the daily clinical meeting and measures will be implemented to ensure that they have an attached e cylinder and cannula when being transported to and return from dialysis and during	

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	2. The record for Resident D was reviewed on 9/11/2023 at 4:27 p.m. Diagnoses included, but were not limited to, chronic kidney disease, acute and chronic respiratory failure with hypoxia, dependence on renal dialysis, and end stage renal disease. The resident had a BIMS of 14. This score indicated the resident was not cognitively impaired. Nursing notes indicated Resident D had a physicians' order, dated 8/16/2023, for oxygen at 2 liters per minute via nasal cannula continuous, may titrate as needed. During an interview, on 9/11/2023 at 4:08 p.m., Resident D was observed to have oxygen at 2 liters with continuous flow while on dialysis. She indicated she receives continuous oxygen when she arrived at the dialysis center for her treatment. On her way to dialysis, the staff disconnect her from her oxygen in her room and she had no oxygen until she gets her turn in dialysis. Sometimes she had to wait at the dialysis center with no oxygen until it was her turn. When she was done in dialysis center, she was disconnected from her oxygen and had to wait for transport to her room, sometimes she had to wait 15 to 20 minutes for her transport without oxygen. She was out of breath after 15 minutes. During an interview, on 9/11/2023 at 4:00 p.m., the Dialysis Nurse indicated the residents came to the dialysis center without oxygen and they were put on continuous oxygen when they were on dialysis. When the resident was finished with their dialysis treatment, she called the staff to transport the resident to their room. The resident was disconnected from oxygen, and they wait for		dialysis treatment and while waiting to receive treatment What corrective action will be accomplished for those residents found to have been affected by the deficient practice: · Residents receiving dialysis orders will be audited in order to identify those that also have oxygen orders. · An audit will be conducted three times a week to ensure that residents are receiving oxygen during transport to and from dialysis treatment and while waiting to begin their dialysis treatment. · Staff will be inserviced on oxygen administration and inserviced on the requirement that oxygen be administered during the transportation and the wait time for dialysis treatment. Exhibit C - Job descriptions and in-services. 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; Weekly audits will be reviewed in monthly QAA to ensure audits are completed and that all dialysis residents with orders for continuous flow oxygen have been reviewed and measures have been taken to ensure they are receiving oxygen during transport to and from dialysis treatment and while	

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	transportation outside the dialysis center. She was not aware when the transportation comes to pick up the resident. The resident could not wait for transport in the dialysis center. The next resident was ready for the treatment and the resident who was finished needed to vacate the space. She indicated she did not know why the resident was not on oxygen during transport to and from the dialysis center. During an interview, on 9/11/2023 at 4:25 p.m., the Assistant Director of Nursing indicated residents on continuous oxygen should be on continuous oxygen throughout the day, evening, and night per physician's orders. The resident should be transported to dialysis with oxygen and then returned from dialysis to their room with oxygen. She was not aware Resident B and D were transported to and from dialysis without oxygen. During an interview, on 9/11/2023 at 4:40 p.m., the Director of Nursing indicated residents on continuous oxygen should be on continuous oxygen throughout the day, evening, and night per physician's orders. The resident should be transported to dialysis with oxygen and then returned from dialysis to their room with oxygen. She was not aware Resident B and D were transported to and from dialysis without oxygen. A policy was not received before the date of exit. This Federal tag relates to Complaint IN00416164. 3.1-47(a)(6)		waiting to begin their dialysis treatment.	