STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

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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 IN00445671. Complaint IN00445671 - No deficiencies related to the allegations are cited. Survey dates: October 29, 30, 31, November 1, and 4, 2024 Facility number: 000007 Provider number: 155019 AIM number: 100275040 Census Bed Type: SNF/NF: 99 SNF: 13 Total: 112 Census Payor Type: Medicare: 13 Medicaid: 62 Other: 37 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 13, 2024.	F 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is files as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this plan of correction (POC) provides the facility's credible evidence of compliance effective November 08, 2024. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the plan of correction (POC) and supporting documents submitted.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure physician orders were followed for 1 of 2 residents reviewed for respiratory care. (Resident 213)	F 0695	**Corrective actions taken:** Immediate action(s) taken for resident #213 were found to have been affected by the alleged	11/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Warren McCreery	Executive Director	11/18/2024

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	Finding includes: On 10/30/24 at 9:56 a.m., Resident 213 was observed to be lying asleep in bed with the oxygen concentrator level set at 3 L (liters) per minute and the N/C (nasal cannula) sitting on her face and not in the nostrils. On 10/30/24 at 2:49 p.m., Resident 213 was observed to be lying asleep in bed with the oxygen concentrator level set at 3 L per minute and the N/C sitting on her face and not in the nostrils. On 11/1/24 at 9:38 a.m., Resident 213 was observed to be lying asleep in bed with the oxygen concentrator level set at 3 L per minute and the N/C in her nostrils. On 11/1/24 at 2:33 p.m., Resident 213 was observed to be lying asleep in bed with the oxygen concentrator level set at 3 L per minute and the N/C sitting on her face and not in the nostrils. On 11/4/24 at 11:06 a.m., Resident 213 was observed to be lying asleep in bed with the oxygen concentrator level set at 3 L per minute and the N/C in her nostrils. Resident 213's clinical record was reviewed on 11/1/24 at 10:00 a.m. The diagnoses included, but were not limited to, anemia, supraventricular tachycardia, and hypertension. Physician orders for Resident 213 indicated, "... Oxygen at 2 L per minute via nasal cannula every shift ...". The start date was 10/11/24.		deficiency include: Resident #213 was assessed by the Director of Nursing Services for immediate concerns. No concerns identified at this time. **How other residents were identified:** All residents who have an order for oxygen have the potential to be affected. 100% audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident that have orders for oxygen are following MD orders on 11/8/24. No further concerns were identified. **Measures in place/system changes.** QAPI meeting was held with the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one and two, Social Services Director, and Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 11/8/24. On 11/5/24, education was initiated and will continue until all RN/LPN care team members have been educated on ensuring that oxygen levels are followed per MD or NP orders. Nursing Management Team including the Director of Nursing, Assistant Director of	

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	During an interview on 11/4/24 at 11:50 a.m., LPN 1 indicated Resident 213's oxygen order was for 3 L per N/C and confirmed the oxygen concentrator was set at 3 L per N/C. On 11/4/24 at 4:07 p.m., the Administrator provided the facility's policy, "Medication Administration," dated 5/20/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Procedure: 1. Preparation/Administration d. Follow the six rights of medication administration ... ii. right dose ..." 3.1-47(a)(6)		Nursing, and Unit Managers. Education completed on 11/5/24. **Monitoring of corrective actions taken:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit oxygen orders and following Physician orders 3X weekly X3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit managers to review audits, education, results, and findings. This action was completed by the Executive Director on 11/8/24. The next QAPI will be held on 12/8/24. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee. **Date of compliance:** November 8, 2024	

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure the posted daily staffing information sheet included the facility name for 5 of 5 daily staffing sheets reviewed. Findings include: On 10/29/24 at 2:30 p.m., the daily nurse staffing information sheet was observed posted near the front entrance door. The staffing information sheet lacked documentation of the facility name. During a review of the posted staffing sheets, dated 10/29/24, 10/30/24, 10/31/24, 11/1/24, and 11/4/24 indicated the staffing information sheets lacked documentation of the facility name. During an interview on 11/4/24 at 3:40 p.m., the Administrator indicated the staffing sheet was printed daily through a new company program. He indicated he was not aware the facility name should be on the report. During a interview on 11/4/24 at 3:58 p.m., the Administrator indicated the facility did not have a policy regarding posted daily staffing information.	F 0732	**Corrective actions taken:** The scheduling system was updated to specifically print out the entire name (Majestic Care of Bloomington). This was identified and fixed companywide while exit was taking place. **How other residents were identified:** No residents were identified at risk. **Measures in place/system changes.** QAPI meeting was held with the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one and two, Social Services Director, and Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 11/8/24. On 11/5/24, Majestic Care Corporation confirmed that all BIPAs would be specific to location and state entire name on daily sheets. **Monitoring of corrective actions taken:** The Executive Director, Director of Nursing, Assistant Director of Nursing, and Facility Scheduler will randomly audit daily BIPA 3X weekly X3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time	11/08/2024

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			consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit managers to review audits, results, and findings. This action was completed by the Executive Director on 11/8/24. The next QAPI will be held on 12/8/24. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee. **Date of compliance:** November 8, 2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure a medication cart on the 300 unit was locked for 1 of 8 medication carts observed. (300 Unit Medication Cart) Findings include: On 10/30/24 from 10:18 a.m. until 10:38 a.m., the medication cart outside of Room 332 was observed to be unlocked and unattended by staff.	F 0761	**Corrective actions taken:** The cart was immediately locked and secured. Immediate Inservice was done with specific nurse. In-servicing was completed for all nurses on 11/5/24. **How other residents were identified:** No residents identified at risk at this time. 100% audit of all other carts was completed by the	11/08/2024

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	The medication cart contained medications for residents on the 300 unit. During an interview on 10/30/24 at 10:39 a.m., RN 1 indicated she had been at the other end of the hallway providing care to residents from another medication cart, and the medication cart was to be locked if it was unattended by staff. On 11/4/24 at 4:00 p.m., the Director of Nursing provided the Facility Drug Product Storage Requirements, revised 2/22/22, and indicated this was the policy currently used by the facility. A review of the policy indicated, "...all drug storage areas shall be kept secure from unauthorized entry and shall be limited to authorized personnel..." 3.1-25(m)		Nursing Management Team including the Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each cart was locked on 11/5/24. No further concerns were identified. **Measures in place/system changes.** QAPI meeting was held with the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one and two, Social Services Director, and Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 11/8/24. On 11/5/24, education was initiated and will continue until all RN/LPN care team members have been educated on ensuring that carts are always locked when not in sight are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, and Unit Managers. Education completed on 11/5/24. **Monitoring of corrective actions taken:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit carts to be locked 3X weekly X3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time	

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