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	05/24/2024

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 IN00432944. Complaint IN00432944 - Federal/State deficiencies related to the allegations are cited at F677 and F689. Survey dates: May 21, 22, 23, and 24, 2024 Facility number: 000477 Provider number: 155570 AIM number: 100290860 Census bed type: SNF/NF: 34 Total: 34 Census payor type: Medicare: 1 Medicaid: 26 Other: 7 Total: 34 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 29, 2024	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 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;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katlyn Collins		06/07/2024

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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	Based on interview, observation, and record review, the facility failed to assist a female dependent resident with perineal care in a manner to promote infection control, provide a dependent resident hair shampooing per her preference, to providing bathing type to a dependent resident's preference, and ensure availability of assistive devices for 1 of 2 residents reviewed for activities of daily living (Resident D). The facility failed to implement the use of long sleeves as a preventative measure for a resident with skin impairments for 1 of 1 residents reviewed for non-pressure skin impairments (Resident 9). Findings include: 1. The clinical record for Resident 9 was reviewed on 5/22/24 at 2:52 p.m. The diagnoses included, but were not limited to, anorexia, generalized anxiety disorder, and dementia. An admission minimum data set (MDS) assessment, dated 3/19/24, indicated severe cognitive impairment and the need for supervision/touching assistance with upper body dressing and partial/moderate assistance with personal hygiene. A skin care plan, dated 4/2/24, indicated Resident 9 had chronic bruising and was at risk for bruising to bilateral arms due to thin fragile skin. A skin impairment care plan, dated 5/20/24, indicated Resident 9 had a skin tear to left lateral arm (elbow) and upper left arm abrasion. There were no interventions on the care plans that consisted of preventative measures such as wearing long sleeves or geri sleeves (protective arm sleeves). There were no current physician	F 0677	**1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice;** a Resident 9 was immediately assisted with placing a long sleeve shirt on. Resident 9 has since been discharged from the facility. b Oxygen placed on 5/21/24 by CNA 5 on Resident D, call light within reach of Resident D. DNS gave resident bed bath, including perineal care on 5/22/24. Resident's hair washed on 5/22/24. c A chart review and resident observation completed 5/24/2024 by DNS revealed no negative findings related to the cited deficient practice for Resident 9 and Resident D. **2. How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All current residents who require extensive-dependent assistance for perineal care, and hair washing will be audited by the leadership team/designees to ensure care is provided and promote infection control practices by 6/7/2024. b. The leadership team will observe all current residents who are care planned to have long sleeves for evidence of long-	06/07/2024

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	orders for geri sleeves. A skin and wound note, dated 3/26/24, indicated a skin tear to the right elbow with a recommendation to "consider geri-sleeves for protection". Resident 9 had a skin tear related to thin, fragile, atrophic skin. Recommended preventing further skin injury by avoiding friction/shear and long sleeves and pants when possible. A skin and wound note, dated 4/2/24, indicated a skin tear to the right elbow, left hand, left wrist, and left elbow. A recommendation listed to "consider geri-sleeves for protection". Resident 9 had a skin tear related to thin, fragile, atrophic skin. Recommended preventing further skin injury by avoiding friction/shear and long sleeves and pants when possible. A skin and wound note, dated 5/21/24, indicated Resident 9 had fallen and obtained a skin tear to the left posterior arm and left elbow. Treatment recommendations were to "consider geri-sleeves". Recommended preventing further skin injury by avoiding friction/shear and long sleeves and pants when possible. An observation conducted on 5/21/24 at 11:05 a.m., of Resident 9 lying in bed with short sleeves on and no geri sleeves in place. An observation conducted on 5/21/24 at 11:57 a.m., of Resident 9 lying in bed with short sleeves on and no geri sleeves in place. An observation conducted on 5/22/24 at 4:45 p.m., of Resident 9 up in the wheelchair in his room with a short sleeve on and no geri sleeves in place. An interview conducted with the Director of		sleeves according to the plan of care by 6/7/2024. c. The leadership team will observe all residents who have an order for oxygen for evidence of oxygen usage according to the plan of care by 6/7/2024. d. The leadership team will observe all residents to ensure call lights are within reach by 6/7/2024. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** A. The DNS/designee will educate CNAs, QMAs, and licensed nurses on the ADL policy and incontinence care policy by 6/7/2024. B. The DNS/designee will educate CNAs, QMAs, and licensed nurses on ensuring interventions are in place according to the kardex/careplan for residents with skin impairments by 6/7/2024. **4. 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 facility leadership will make 5 random resident observations per week to ensure that perineal care is provided correctly, hair is clean/washed, call lights are in place, oxygen is on and in place and residents have skin	

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	Nursing (DON), on 5/23/24 at 3:07 p.m., indicated Resident 9 would remove gauze wraps and geri sleeves when it was trialed with him. They believed Resident 9 wearing long sleeves would be a different approach to attempt with him as an intervention. A policy titled "Skin Management", dated January 2022, was provided by the DON on 5/23/24 at 9:25 a.m. The policy indicated the following, " ...PREVENTION ...a) Care plan interventions will be implemented based on resident specific risk factors ...7. Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place ...a) A care plan will be developed specific to the resident's needs including prevention interventions ...." 2. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnosis included a history of stroke. An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact, did not have psychosis, did have verbal behaviors directed at others 1-3 days during the review period, and did not reject care. Activities of daily living indicated that Resident D was dependent on staff for showering/bathing and for transferring. An activities of daily living care plan, dated 4/17/2023, indicated that Resident D needed assistance of one staff to prove her with bathing on her shower days and assistance of one staff for hygiene needs. A fall care plan, dated 4/29/2023, indicated to keep Resident D's call light within reach.		impairment interventions in place according to the plan of care weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be developed. Clinical leadership will competency 3 random CNAs on proper incontinence care per week x 4 weeks. All findings will be presented to the QAPI committee during the monthly meeting, and as needed.	

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	A respiratory care plan, dated 4/17/2023, indicated for Resident D to utilize oxygen as ordered. A physician order, dated 12/5/2023, indicated for Resident D to have oxygen therapy at three liters per minute. A preference assessment, dated 3/22/2024, indicated that it was very important for Resident D to make decisions regarding her bathing. A task, dated 12/4/2023, indicated for Resident D to receive showers on Monday and Thursday evenings. An observation on 5/21/2024 at 12:09 p.m., indicated CNA 4 and CNA 5 provided Resident D with a bed bath, perineal care, catheter care, and transfer from her bed to her wheelchair. During this care, Resident D did not receive shampooing of the hair but was set up to brush her hair once in the wheelchair. At the beginning of the care, Resident D was observed to utilize oxygen via nasal cannula at three liters per minute. During the observation at 12:22 p.m., CNA 5 assisted Resident D to roll towards CNA 4. CNA 5 assisted Resident D with cleaning a small amount of bowel movement. Resident D was indicated that staff had not gotten her cleaned up well enough over the weekend and she felt like she was sore "down there". CNA 5 wiped from the anus towards the vaginal opening, folded the washcloth to repeat this, then repeated this actions once more. CNA 5 discarded the used washcloth then changed her gloves then used a new washcloth to wipe off Resident D's bottom of the soapy residue. Later in that observation on 5/21/2024 at 12:50 p.m., Resident D had her oxygen removed due to it becoming tangled when her shirt when she was dressed in bed. Both CNAs began assisting			

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	Resident D to untangle the oxygen but neither placed it back upon Resident D. CNA 4 exited the Resident's room at 12:55 p.m. CNA 5 left the room at 12:57 p.m. to retrieve something from outside of the room. Resident D was left in bed without a staff member present with the foot of her bed pulled out from the wall, her call light was not given to her, and her oxygen was not placed. At 12:58 p.m., Resident D began to call out loudly that she could not breath without her oxygen and that she needed her oxygen. At 12:00 p.m. both CNAs returned to the room. Resident D was still calling out for her oxygen and ice pack. CNA 5 placed the oxygen back to Resident D via her nasal cannula and informed her that the staff were able to get her up to her recliner. An interview and observation with Resident D on 5/21/2024 at 4:01 p.m. indicated that she was blind after her stroke. She stated that she had not had her hair washed since March of this year and that her hair "smelled" to her. Her hair appeared somewhat unkempt, specifically at the nape of her neck where it appeared tangled with some slight build up. She stated her preference was to have a shower in the shower room, but she has been here a year, and no one has ever taken her into the shower room. She stated she doesn't feel like bed baths get her clean enough. She stated she would like to receive showers every day since that was her routine when she could "care for herself", but she "understands that isn't possible". She iterated instead she was comfortable with receiving showers and have her hair shampooed twice a week "like everyone else" with her bed baths in between, but she stated she is not receiving showers in the shower room or shampooing of her hair. She indicated she does not like to use shampoo caps because they leave residue in her hair.			

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	A shower sheet was provided for Resident D, dated 5/21/2024. There was a place to indicate yes or no if a shower was given, and what type of bathing was provided such as a bed bath, shower, or resident refused. Both locations were left blank. Review of the electronic care documentation indicated that Resident D last documented hair wash under this task was on 5/2/2024. Review of previous shower sheets had types of bathing (shower, bed bath, completed bed bath) indicated intermittently, but not always. The last documented complete bed bath from the paper shower sheets was completed on 5/16/2024. A shower sheet from 5/19/2024 did not indicate what type of bathing or care was provided. An interview with Resident D with staff on 5/23/2023 at 12:09 p.m., indicated she preferred showers and had not had her hair shampooed since March of this year. Resident D stated again that her hair "smelled" and asked a staff member conducting the interview how often they washed their hair. In response to the staff member's answer, Resident D stated that she wanted her hair shampooed twice a week. An interview with the Executive Director on 5/23/2024 at 3:20 p.m. indicated that shower preferences would be indicated under the resident's tasks. An interview with Resident D on 5/24/2024 at 12:48 p.m. reiterated that she had not received a shower in the shower since her admission here and did not have her hair shampooed since March of this year.			

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	A document entitled, "Resident Rights", was provided by the Director of Nursing on 5/23/2024 at 3:15 p.m. The resident's right included the right to be informed of, and participate in, the resident's treatment including the right to determine the type, frequency, and durance of care. Another resident right was indicated as the right to make choices about aspects of the resident's life in the facility that are significantly important to the resident. A policy entitled, "Perineal Care", was provided by the Director of Nursing on 5/21/2024 at 3:15 p.m. The policy indicated, "...Cleanse buttocks and anus, front to back; vagina to anus in females..." A policy entitled, "Use of Assistive Devices", was provided by the Executive Director on 5/22/2024 at 4:55 p.m. The policy indicated that the facility would provide assistive devices for residents as needed. This Federal tag relates to Complaint IN00432944. 3.1-3(v)(1) 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-47(a)(6)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §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			

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	adequate supervision and assistance devices to prevent accidents. Based on interview, observation, and record review, the facility failed to implement the use of padded side rails for two residents with a care planned for seizure disorders (Resident 9 and Resident D) and failed to utilize a Hoyer lift pad to the manufacturer's guidelines for 1 of 2 residents reviewed for accidental hazards. (Resident D) Findings include: 1. The clinical record for Resident 9 was reviewed on 5/22/2024 at 2:33 p.m. The medical diagnoses included dementia and psychosis disorder. An Admission Minimum Data Set (MDS) Assessment, dated 3/19/2024, indicated that Resident 9 was cognitively impaired and had a seizure disorder or epilepsy. A seizure care plan, dated 3/8/2024, indicated for Resident 9 to utilize padded side rails. An observation on 5/21/2024 at11:05 a.m. indicated Resident 9 laying in bed with a white bed without padding. An observation on 5/22/2024 at 2:45 p.m. indicated Resident 9 laying in bed with a white bed rail without padding. An interview with LPN 3 on 5/22/2024 3:01 p.m., indicated that Resident 9's bed rails were not padded. 2. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnosis included a history of stroke.	F 0689	**1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice;** a. Resident D and 9 had padding placed on siderails by DNS on 5/24/2024. b. CNA 4 was educated by DNS on hoyer lift use according to the manufacturer guidelines on 5/22/24, a competency was completed for proper use of the hoyer lift by DNS on 5/22/24. CNA 5 was educated by DNS on hoyer lift use according to the manufacturer guidelines on 5/22/24, a competency was completed for proper use of the hoyer lift by DNS on 5/22/24. c. DNS/designee completed a chart review/ resident observation of Resident D and Resident 9 with no negative findings related to the cited deficient practice 5/24/2024. **2. How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents with diagnosis of seizures will be audited by facility leadership to ensure that seizure precautions are in place according to the resident's plan of care 6/7/2024. b. All residents who require a hoyer lift will have an	06/07/2024

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	An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact, did not have psychosis, did have verbal behaviors directed at others 1-3 days during the review period, and did not reject care. Activities of daily living indicated that Resident D was dependent on staff for showering/bathing and for transferring. A seizure care plan, dated 4/17/2023, indicated for Resident D to utilize padded side rails. An observation on 5/21/2024 at 12:13 p.m. indicated Resident D laying in bed without padded side rails. An observation on 5/22/2024 at 2:40 p.m. indicated Resident D laying in bed without padded side rails. An interview with CNA 6 on 5/22/2024 at 2:42 p.m. indicated Resident D did not have padded side rails. A policy entitled, "Use of Assistive Devices", was provided by the Executive Director on 5/22/2024 at 4:55 p.m. The policy indicated that the facility would provide assistive devices as needed for residents. A fall care plan, dated 4/29/2023, indicated Resident D had a transfer status that required the use of two staff members and a Hoyer (full body mechanical) lift. An interview and observation on 5/21/2024 at 1:12 p.m. indicated CNA 5 rolled Resident D towards the wall where CNA 4 was located. The Hoyer lift sling was placed partially under Resident D. CNA 4 then assisted Resident D in rolling back to the		observation/competency completed by clinical leadership on use of the hoyer during a transfer 6/7/2024. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. All clinical staff will be educated by the DNS by 6/7/2024 regarding residents with seizure disorders to have interventions in place according to their plan of care and manufacturers guidelines on the use of hoyer lift pads. **4. 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;** a. DNS/designee will make 3 random observations of residents with seizure diagnosis fore evidence of intervention consistent with the plan of weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be developed. b. DNS/desigee will complete 3 random hoyer lift competencies per week for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be developed. All findings will be presented to the QAPI committee during the	

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	right side of her bed, open to the center of the room, to finish placing the Hoyer lift sling under Resident D. CNA 5 obtained the Hoyer lift from the center of the room and began to lower the arm of the lift for ease of placing the loops. CNA 4 indicated "white" to CNA to direct that color of loop they would utilize to lift Resident D. CNA 4 and CNA 5 placed the loops upon the lift support hooks starting with Resident D's left shoulder then left leg, right leg, and finishing with the right shoulder. The leg straps were placed on the Hoyer lift support hook without crossing the leg straps. During the placement of the loops, they had to pause to lower the arm slightly more due to tension when placing the last loop associated with the right shoulder. At 1:17 p.m. on 5/21/2024, CNA 5 guided the lift and CNA 4 guided Resident D. CNA 4 helped turn Resident D once she was suspended in the sling and moved from the bed to straddle the boom of the Hoyer lift while CNA 5, at the control of the lift, helped guide Resident D's leg to move around the boom. The staff attempted to get Resident D into her recliner per her request, but the recliner was noted to not be plugged. CNA 4 went behind the recliner, sliding it out from the wall some, and then picked up a black cord but was unable to find where it plugged in. Resident D began to loudly state that her back hurt and that she was slipping. Resident D then agreed to get in her wheelchair. CNA 4 repositioned Resident D's wheelchair to be placed in the middle of the room, facing the room door, before Resident D was then maneuvered into her wheelchair. A policy entitled, "Safe Resident Handling/Transfers", was provided by the Director of Nursing on 5/21/2024 at 3:15 p.m. The policy indicated, " ...Staff will perform mechanical lists/ transfers according to the manufacturer's instructions for use of the device ..."		monthly meeting.	

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MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

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	An Operator's Manual for the Hoyer lift utilized was provided by the Executive Director on 5/22/2024 at 12:49 p.m. The manual indicated when attaching the sling to lift to attach right shoulder strap to the nearest sling support hook then repeat for the left shoulder strap. The manual emphasized not to crisscross the shoulder straps. The manual indicated to be sure leg straps are properly crisscross as shower in a diagram then attached to sling support hooks away from the resident. This Federal tag relates to Complaint IN00432944. 3.1-45(a)(2)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to have a Registered Nurse (RN) on duty for 8 consecutive hours per day for 6 days during the months of April and May of 2024 with the	F 0727	**1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice;** a. Implementation of process to	06/07/2024

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	potential to affect 32 of 32 residents residing at the facility. Findings include: The Director of Nursing (DON) provided the daily schedules for April 2024 until May 24, 2024. The following dates were noted without RN coverage for 8 consecutive hours: 4/13/24, 4/14/24, 4/27/24, 4/28/24, 5/11/24, & 5/12/24. An interview conducted with the DON, on 5/23/24 at 9:52 a.m., indicated there were no RN hours that consisted of 8 consecutive hours for the days listed.		review of RN coverage initiated by ED on 5/28/2024. New Full time RN hired on 6/4/2024. **2. How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All current residents were reviewed by way of chart reviews by the clinical management team with no negative findings related to the cited deficient practice on 5/24/2024. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Director of Nursing has been educated by Executive Director on 6/7/2024 on requirement of RN coverage 7 days a week for at least 8 hours a day. Will work with ISDH to obtain short term RN coverage waiver if needed in the future. **4. 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;** a. Executive Director will utilize RN hours tool to audit for daily RN coverage weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be	

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			developed. All findings will be presented to the QAPI committee during the monthly meeting.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and			

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	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility administered a resident his antipsychotic medication in excessive dosage for 1 of 5 residents reviewed for unnecessary medication. (Resident H) Findings include: The clinical record for Resident H was reviewed on 5/21/24 at 1:50 p.m. His diagnoses included, but were not limited to, psychotic disorder with delusions, major depression, and dementia. The psyche (psychiatric/psychological) services care plan, revised 6/23/23, indicated he received services through the facility's provider related to major depression, psychotic disorder, and dementia. An intervention was medication management though the facility's provider. An interview was conducted with Family Member 11 on 5/21/24 at 1:57 p.m. She indicated she thought Resident H was receiving too many psychotropic medications at the facility. He had a	F 0758	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Resident H antipsychotic order was identified and corrected to the ordered dosage on 2/16/2024 by DNS. No adverse side effects from this event. **2. How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents on antipsychotic medications will be audited by clinical management/designee to ensure the dosage is consistent with the providers orders/recommendations by 6/7/2024. **3. What measures will be put into place and what systemic**	06/07/2024

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	medication change regarding one of his antipsychotic medications earlier this year, but the facility never notified her of the change. The 2/9/24 psyche note read, "Resident has a history of delusions and agitation, none noted today. Continue Risperdal 0.5 mg twice daily. Continue to monitor for new or worsening delusions or behaviors." The 2/9/24 physician orders indicated to administer two 0.25 mg tablets (0.5 mg total) of Risperdal two times a day, starting 2/9/24. The electronic health record indicated Resident H received 0.5 mg of Risperdal 3 times a day between 2/10/24 and 2/15/24. An interview was conducted with the DON on 5/23/24 at 12:52 p.m. She indicated there was no verification the facility notified Family Member 11 of Resident H's 2/9/24 Risperdal medication change. They probably called Family Member 11 to inform her, but she was likely unavailable, and the call was not documented. The 2/16/24 Note To Attending Physician/Prescriber indicated Resident H had been taking Risperidone 0.75 mg in the morning and 0.5 mg in the evening. On 2/9/24, a provider progress note indicated a plan to decrease Risperidone to 0.5 mg BID (twice daily.) The 0.75 mg morning order was discontinued and a new order for 0.5 mg twice daily was added, but the existing 0.5 mg evening order remained active in the facility's electronic health record. This resulted in a current dose of 0.5 mg three times daily which was not intended. "Recommend immediate update of [name of electronic health record] orders to match provider intended order of 0.5 mg BID."		**changes will be made to ensure that the deficient practice does not recur;** a. all nurses will be educated by the DNS by 6/7/2024 regarding residents receiving proper antipsychotic dosage in accordance with providers orders/recommendations. **4. 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;** a. DNS will utilize psychotropic order change tool to audit all new antipsychotic medication orders and providers recommendations for antipsychotics weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be developed. All findings will be presented to the QAPI committee during the monthly meeting.	

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	The 2/23/24 physician/prescriber response section of the note read, "Risperdal dose corrected to 0.5 mg bid." An interview was conducted with the DON (Director of Nursing) on 5/24/24 at 11:11 a.m. She indicated on 2/9/24 she entered a new Risperdal order of 0.5 mg twice daily, discontinued the 0.75 mg morning order for Risperdal, but did not discontinue the 0.5 mg evening order of Risperdal. The 2/9/24 Risperdal change should have been a decrease, but in error, it was an increase. The Use of Psychotropic Medication policy was provided by the DON on 5/24/24 at 12:57 p.m. It read, "Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s)." 3.1-48(a)(1)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments			

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	under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to properly store a medicated cream for 1 of 1 residents reviewed for medications at the bedside (Resident D) and failed to ensure the medication carts did not contain expired insulin for four residents for 2 of 2 medication carts observed. (Residents 1, 2, 4 and 8) Findings include: 1. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnosis included a history of stroke. An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact. An observation on 5/21/2024 at 12:14 p.m. indicated a container of medicated cream with a pharmacy label for Resident D was being stored on an open front white shelf above the television stand in Resident D's room. An observation on 5/22/2024 at 12:40 p.m. indicated the container of medications cream with	F 0761	**1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice;** a. Identified medication was removed from bedside by LPN 2 on 5/22/24. b. Medication/Insulin found to be out of compliance with labeling/dating policy were discarded immediately upon finding by DNS on 5/22/24. **2. How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by deficient practice. Medication carts were audited for expired medications by DNS on 5/28/24. No concerns noted. All residents' rooms audited for medications on 5/28/24 by DNS. No concerns noted.	06/07/2024

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	a pharmacy label for Resident D remained on the while shelf in Resident D's room. An observations and interview with LPN 2 on 5/22/204 at 12:46 p.m. indicated the container of medications cream with a pharmacy label for Resident D was on the shelf in Resident D's room. LPN 2 confirmed this was a currently ordered medicated cream for Resident D, the container was open, and should not be stored in Resident D's room. LPN 2 then removed the cream from Resident D's room. 2. An observation was conducted of a medication cart with Licensed Practical Nurse (LPN) 3 on 5/22/24 at 9:10 a.m. There was Humalog (fast acting insulin) for Resident 2 with the bottle dated for 3/14/24. LPN 3 indicated Resident 2 doesn't receive the sliding scale insulin that often. An observation was conducted of another medication cart with LPN 2 on 5/22/24 at 9:20 a.m. There was bottle that contained Fiasp injection (fast acting insulin) with a date of 3/16/24 for Resident 1. There was a bottle that contained insulin lispro (fast acting insulin) for Resident 8 that was dated for 4/7/24. There was a bottle that contained Novolog (fast acting insulin) for Resident 4 dated for 4/13/24 and a bottle that contained Lantus (long-acting insulin) dated for 3/16/24. LPN 2 indicated when she opened the bottles where the insulin was stored in, the vials had dates consistent with the dates listed on the bottles. An interview conducted with DON, on 5/23/24 at 3:07 p.m., indicated the pharmacy came out last month and audited the medication carts. The pharmacy conducted audits monthly. The night shift staff conducted audits of the medication carts as well.		**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** a. All nurses will be educated by the DNS by 6/7/24 regarding medication storage, and expired drug policies. **4. 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;** a. DNS will utilize Medication Storage tool to audit medication carts and resident rooms for medications weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be developed. All findings will be presented to the QAPI committee during the monthly meeting.	

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	A policy titled "Medication Storage", undated, was provided by the Director of Nursing (DON) on 5/22/24 at 1:32 p.m. The policy indicated the following, " ...1. General Guidelines ...a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls ...b. Only authorized personnel will have access to the keys to locked compartments ...3. External products: Disinfectants and drugs for external use are stored separately from internal and injectable medications ...8. Unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels ...." 3.1-25(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,			

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	identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observations, interview, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP) for 1 of 5 residents reviewed for infection control. (Resident D) Findings include: 1. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnoses included history of a stroke and overactive bladder. An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact and utilized an indwelling urinary device. A care plan, dated 3/28/2024, indicated to utilized a gown and gloves during high contact care with Resident D. A physician order, dated 12/29/2023, indicated Resident D had an indwelling urinary device in the form of a suprapubic catheter. A physician order, dated 3/27/2024, indicated to utilize enhanced barrier precautions during high	F 0880	**1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice;** a. CNA 4 was educated by DNS on enhanced barrier precautions on 5/21/24, a competency was completed for donning of proper EBP ppe by DNS on 5/21/24. CNA 5 was educated by DNS on enhanced barrier precautions on 5/21/24, a competency was completed for donning of proper EBP ppe by DNS on 5/21/24. b. A chart review and resident observation of Resident D completed by DNS/designee revealed no negative outcomes related to the cited deficient practice on 5/24/24. **2. How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	06/07/2024

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	contact care activity with Resident D. An observation started on 5/21/2024 at 12:13 p.m., indicated CNA 4 and CNA 5 providing Resident D with a bed bath, catheter care, and transfer. Resident D had an indwelling suprapubic urinary catheter. Both CNAs utilized universal precautions of disposable gloves during the care, but neither utilized the enhance barrier precautions of a gown. An interview with CNA 5 on 5/21/2024 at 1:11 p.m. indicated that they usually use enhanced barrier precautions of gloves and gown when providing direct care to Resident D, but it had slipped both her and the other CNA's mind. A policy entitled, "Enhanced Barrier Precautions", was provided by the Director of Nursing on 5/21/2024 at 3:15 p.m. The policy indicated that the facility would utilize EBP for residents with indwelling medical devices, including urinary catheters. EBP included the utilization of gown and gloves during high contact resident care, including bathing, transferring, and device care. 3.1-18(a)		a. All residents that are currently in enhanced barrier precautions will have an observation completed by facility leadership to ensure that staff are utilizing EPB precautions by 6/7/24. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. All staff will be educated by the DNS/designee by 6/7/24 regarding Enhanced Barrier Precautions. **4. 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;** a. DNS will utilize EBP tool to audit compliance with precautions weekly for 4 weeks, bi-monthly X 2 and monthly X 4 months, if 100% threshold is not achieved an action plan will be developed. All findings will be presented to the QAPI committee during the monthly meeting.	