STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155247	A. BUILDING 00 B. WING	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTHPORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00408490, IN00408640, IN00409169, and IN00409435. This visit resulted in a Partially Extended Survey- Substandard Quality of Care-Immediate Jeopardy. Complaint IN00408490 - No deficiencies related to allegations were cited. Complaint IN00408640 - No deficiencies related to allegations were cited. Complaint IN00409169 - No deficiencies related to allegations were cited. Complaint IN00409435 - Federal/State deficiencies related to the allegations are cited at F698. Unrelated deficiencies are cited. Survey dates: May 26, 27, 30, and 31, 2023 Facility number: 000151 Provider number: 155247 AIM number: 100284060 Census Bed Type: SNF: 1 SNF/NF: 70 Total: 71 Census Payor Type: Medicare: 1 Medicaid: 59 Other: 11 Total: 71	F 0000		

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 2, 2023.			
F 0689 SS=J 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 adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure staff were properly securing the bus safety latch before transporting residents for 3 of 3 residents reviewed for accidents hazards. Resident D sustained fractures to both legs. Resident B sustained minor injuries. (Resident D, Resident B, Resident E) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began, on 12/29/22 at approximately 5:00 p.m. when the facility failed to secure a resident's wheelchair prior to transporting that resident in the facility bus. The Administrator was notified of the Immediate Jeopardy on 5/30/23 at 4:40 p.m. The Immediate Jeopardy was removed on 5/31/23 at 3:30 p.m., but noncompliance remained at a lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.	F 0689	It is the practice of this provider to ensure that residents riding on the facility bus/van will be secured using all safety mechanisms including but not limited to safety belt. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident D, B, E had appropriate follow up completed at time of incident. No further follow up need currently. MD/NP made aware of deficient practice. No new orders or changes in plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who transport on the	06/16/2023

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	Findings include: 1. During an interview on 5/30/23 at 12:12 p.m., Resident D indicated the Maintenance Director was driving the facility bus when Resident D was being transported. The Maintenance Director stopped the bus and Resident D fell forward out of his wheelchair and the wheelchair moved forward. Resident D's legs were pinned between his motorized wheelchair and the bus seat. He indicated his wheelchair wasn't secured to the floor either. Resident D indicated the Maintenance Director was in a hurry. Resident D indicated he didn't put his wheelchair seat buckle on because he was used to being strapped in once on the bus. Resident D thought his right leg "looked like the bone was going to come out." The Maintenance Director did not secure Resident D's motorized wheelchair to the bus floor. The Maintenance Director did not put the seat belt on Resident D. During an interview on 5/30/23 at 12:49 p.m., the Maintenance Director indicated Resident D was sitting in his motorized wheelchair while being transported in the facility bus. The Maintenance Director was driving and came to a stop. Resident D "flipped" out of the wheelchair. This was not the Maintenance Director's first time driving the facility bus to transport residents. The clinical record for Resident D was reviewed on 5/30/23 at 3:13 p.m. The diagnoses included, but were not limited to, paraplegia and post traumatic stress disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 4/12/23, indicated Resident D was cognitively intact. A hospital progress note, dated 12/29/22 at 6:19		facility bus/van are at risk for deficient practice. ED/Designee will complete and audit of recent transports for the last 30 days to ensure that each resident has utilized the safety belt and was free from any accidents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ED/Designee will in-service facility transport staff on Transportation policy on or before June 16, 2023. ED/ Designee will complete daily audit tool of the daily transportation tool to ensure that the bus safety mechanisms are in proper working condition. This will be completed x 30 days; areas will thereafter be monitored through the Safety/Van Transportation QA tool.	

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	p.m., indicated Resident D presented to the emergency department after he fell forward from his wheelchair because he was not secured in the transport van. Noted twisted legs. A hospital progress note, dated 1/1/23 at 11:16 a.m., indicated Resident D sustained a right tibial shaft fracture (right lower leg), a left femur fracture (left upper leg), and a left tibial fracture just below the knee. 2. During an interview on 5/26/23 at 11:01 a.m. Family Member 1 indicated she was with Resident B, on the facility bus, when the bus driver crossed a median and Resident B fell out of his wheelchair. Resident B hit his head, had a cut on his elbow, and a cut on his finger. Resident B also told Family Member 1 that his neck was hurt. The bus driver didn't have Resident B strapped in. The bus driver told her the straps didn't work. During an interview on 5/26/23 at 12:32 p.m., Bus Driver 1 indicated she was transporting Resident B on 5/15/23 when he slid out of his wheelchair when she made a wide turn. Resident B's wheelchair was secured to the floor but the seat belt that was supposed to secure Resident B was broken so she did not apply the seatbelt. The bus driver thought the seat belt was fixed, on May 17 or 18, 2023, when she used the bus again for transportation. The clinical record for Resident B was reviewed on 5/26/23 at 12:45 p.m. The diagnoses included, but were not limited to, heart failure and end stage renal disease. An Admission MDS assessment, dated 5/4/23, indicated Resident B was cognitively intact.			

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	A progress note, dated 5/15/23 at 4:13 p.m., indicated skin assessment was completed on Resident B. A skin tear was noted on Resident B's right elbow and his right 5th finger. A progress note, dated 5/15/23 at 4:59 p.m., indicated Resident B had an appointment and was being transported by the facility bus. When the bus came to a construction site, the bus driver had to make a "u" turn and Resident B's wheelchair fell over. Resident B indicated that he hit his head and that he was having neck pain. The Nurse Practitioner was notified, and a physician's order were received for a cervical spine x-ray. Staff educated on importance of making sure residents are properly secured on bus during transports. 3. On 5/30/23 at 1:43 p.m., Resident E was sitting in a wheelchair on the facility bus. Bus Driver 1 was observed to attempt to secure Resident E and the wheelchair in the facility bus. First, Bus Driver 1 moved Resident E's wheelchair into position to be secured. Second, she pulled a strap, with a hook at the end, up from the floor and attached the hook to the wheelchair's wheel. Then, she tightened the strap. This was repeated for each wheel until the wheelchair was secured to the bus floor. Next, she pulled a seat belt from above Resident E's left side down across his chest and another seat belt up from the floor on Resident E's right side. Each seat belt had a buckle attached to the end. She connected the buckles near Resident E's right thigh. After that she indicated Resident E was secured with the seat belts and ready for transport, observed the seat belt that came up from the floor, easily, come apart when slight pressure was applied. At that time, Bus Driver 1 indicated the seat belt was not broken.			

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	The clinical record for Resident E was reviewed on 5/30/23 at 3:31 p.m. The diagnoses included, but were not limited to, paraplegia and post traumatic stress disorder. A Quarterly MDS assessment, dated 3/30/23, indicated Resident E was cognitively intact. On 5/30/23 at 4:32 p.m., the Administrator provided a copy of an undated document, titled employee training orientation, and indicated this was the employee training completed to transport residents in the facility bus. A review of the document indicated the safety gear on the facility van is to be inspected before and after each use. Ensure the resident is secure and double check all locks and restraints. The Immediate Jeopardy, that began on 12/29/22, was removed on 5/31/23 when the facility inserviced the staff on transporting residents in the facility bus via wheelchair to ensure they are secured properly, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. 3.1-45(a)(1)			
F 0698 SS=K Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and			

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	preferences. Based on interview and record review, the facility failed to provide transportation to and from dialysis for 7 of 7 residents reviewed. Four residents missed dialysis appointments and required emergency care due to decline in condition. (Resident B, Resident C, Resident F, Resident G, Resident H, Resident J, Resident K) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 5/22/23 at approximately 8:00 a.m. when the facility failed to provide transportation to and from dialysis for 2 residents. The Administrator and the Regional Nurse were notified of the Immediate Jeopardy on 5/26/23 at 1:30 p.m. The Immediate Jeopardy was removed on 5/27/23 at 9:45 a.m., but noncompliance remained at a lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. During an interview on 5/26/23 at 11:36 a.m., the Administrator indicated the transportation company that was supposed to transport Resident C to dialysis called the facility to let them know they had a staff member call off of work so they would not be able to transport Resident C. Resident C required a stretcher for transport. The facility was unable to reschedule transportation for Resident C to go to dialysis. Resident C died at the emergency department. During an interview on 5/26/23 at 12:32 p.m., Bus Driver 1 indicated Resident C required a stretcher for his transportation so she would not have been able to transport Resident C in the facility bus.	F 0698	It is the practice of this provider to ensure that each resident that requires transportation to dialysis is transported. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides in facility. Resident B, Resident F, Resident G, Resident H, Resident J, all had transportation set-up or were transferred to ensure that they received dialysis treatment. MD/NP made aware of deficient practice. No new orders or changes in plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents that require dialysis are at risk for deficient practice. ED/Designee completed an audit of all residents that required dialysis during survey to ensure that transportation was arranged. No other residents were found to be affected by deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All licensed staff were educated on transportation policy/practices on/before 05.25.2023. Residents that miss dialysis transportation	06/16/2023

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	The clinical record for Resident C was reviewed on 5/26/23 at 1:15 p.m. The diagnoses included, but were not limited to, heart failure, diabetes mellitus, and chronic kidney disease. An Admission MDS (Minimum Data Set) assessment, dated 4/29/23, indicated Resident C was cognitively intact and was receiving dialysis while a resident at the facility. The Physician's Orders included, but were not limited to: Hemodialysis, five times a week, Monday through Friday, initiated 4/23/23. No discontinue date. Appointment on 5/24/23 for hemodialysis. A progress note, dated 5/22/23 at 11:17 a.m., indicated Resident C's daughter was contacted to notify her that resident does not have transportation set up for dialysis and did not attend dialysis today. The plan to be set up for dialysis was Monday, Wednesday, and Friday for the next two weeks, beginning Wednesday 5/24/23. A progress note, dated 5/24/23 at 10:58 a.m., indicated Resident C denied any nausea this morning and did not show signs or symptoms of not receiving dialysis. A progress note, dated 5/25/23 at 5:46 a.m., indicated Resident C complained of upset stomach and lower back pain. As needed medication given, but no change. Resident C's vitals were checked oxygen saturation was 88 percent at 3 LPM (liters per minute of supplemental oxygen), bumped oxygen up to 4 LPM. Oxygen saturation at 99 percent on 4 LPM upon first check. Rechecked 2 hours later oxygen saturation at 93 percent on 4 LPM, then oxygen		will be transported by facility bus/van if applicable for all w/c transports if alternate transport is unavailable. Residents that miss dialysis that require stretcher transportation will be sent to the emergency department per md orders. IDT will complete daily audit tool to ensure that residents requiring dialysis were transported per orders. This will be completed x 30 days; areas will thereafter be monitored through the Dialysis QA tool. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Designee will complete the Dialysis QA Tool weekly x 4, bi-weekly x 2, and monthly x 4 and then at least quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **By what date the systemic change will be completed?** June 16,2023	

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	saturation dropped to 88 percent on 4 LPM. Resident C was pale with bluish lips. A progress note, dated 5/25/23 at 8:45 a.m., indicated Resident C complained of upset stomach. This writer went to Resident C's room to administer morning medications and medication for upset stomach. Resident C took all of his medications without issues, followed by 8 ounces of water. This writer noticed Resident C was very pale in color and mottling (discoloration to the skin when the body starts directing blood to the vital organs) had started in Resident C's bilateral lower extremities. Vitals taken oxygen saturation at 90 percent on 2 LPM, respirations were labored at 14 per minute, the head of bed was raised, and findings reported to the Unit Manager. Upon Unit Manager assessing Resident C, the decision was made to call 911 for evaluation. This writer went back to Resident C's room with crash cart and to stay with Resident C until paramedics arrived. While waiting for the paramedics to arrive, Resident C stopped breathing. CPR (cardiopulmonary resuscitation) began immediately until paramedics, and fire department arrived. Code blue was called, care passed on to paramedics upon their arrival. Resident C's family notified of condition. Resident C did not receive a dialysis treatment, on 5/22/23, 5/23/23, 5/24/23. Resident C was sent to the emergency department, on 5/25/23, where he died. 2. During an interview on 5/26/23 at 11:01 a.m., Family Member 1 indicated she believed her husband had missed one or two dialysis treatments. She asked why the facility bus didn't take Resident B to the dialysis treatment, but she			

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	didn't get an answer. Resident B had been receiving dialysis Monday through Friday at the facility. On 5/23/23, Family Member 1 went to the nurse to ask about Resident B not receiving the dialysis treatment and was told Resident B was going to be sent to the emergency department when he returned from another appointment. At the hospital, the hospital doctor told her Resident B had 4 liters of fluid removed. Normally Resident B had 1 liter of fluid removed at each dialysis treatment. She indicated Resident B was still at the hospital on that date (5/26/23). During an interview on 5/26/23 at 11:36 a.m., the Administrator indicated the transportation company that was supposed to transport Resident B did not show up on the morning of 5/23/23. She indicated the facility attempted to contact them for a reason but did not get an answer. She indicated the facility attempted to find transportation for Resident B but was unsuccessful. During an interview on 5/26/23 at 12:32 p.m., Bus Driver 1 indicated she had not been asked to transport Resident B to dialysis until 5/25/23. Resident B was sent to the hospital and admitted a couple days before that, so she didn't transport Resident B on 5/25/23. Bus Driver 1 worked the morning of 5/23/23. She had to leave at 10:00 a.m., to take another resident to an appointment. She was never asked to transport Resident B to dialysis on 5/23/23. The clinical record for Resident B was reviewed on 5/26/23 at 12:45 p.m. The diagnoses included, but were not limited to, heart failure, diabetes mellitus, and end stage renal disease. An Admission MDS assessment, dated 5/4/23,			

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	indicated Resident B was cognitively intact and received dialysis while a resident at the facility. The Physician's Orders, included, but were not limited to: Hemodialysis, 5 times a week, Monday through Friday, dated 5/1/23 through 5/25/23. Hemodialysis, three times a week, Tuesday, Thursday, Saturday, initiated 5/25/23. A progress note, dated 5/23/23 at 6:23 a.m., indicated staff called transportation company due to Resident B had a scheduled pick up time of 6:00 a.m., and transport had not arrived. The transport company was not able to provide an estimated time of arrival for transportation. A progress note, dated 5/23/23 at 4:24 p.m., Resident B returned from appointment and was complaining of shortness of breath. The Nurse Practitioner was notified and gave verbal order to send Resident B to the emergency department. Resident B did not receive a dialysis treatment on 5/22/23 and 5/23/23. Resident B was transferred to the emergency department on 5/23/23. 3. During an interview on 5/27/23 at 8:35 a.m., the MDS Coordinator indicated Resident F missed dialysis treatments because the facility could not get transportation nor an appointment for his dialysis treatments. Resident F was discharged to another facility to receive routine dialysis treatments there. The clinical record for Resident F was reviewed on 5/30/23 at 9:27 a.m. The diagnoses included, but were not limited to, end stage renal disease and			

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	heart failure. An Annual MDS assessment, dated 3/31/23, indicated Resident F was cognitively intact. The Physician's orders, included, but were not limited to: Hemodialysis 5 times a week Monday through Friday, initiated on 1/4/23 and discontinued on 5/25/23. A progress note, dated 5/22/23 at 3:32 p.m., indicated Resident F did not receive a dialysis treatment. A progress note, dated 5/22/23 at 3:34 p.m., indicated Resident F's mother was contacted, but there was no answer. Voicemail was left to inform her that as of now Resident F didn't have a dialysis chair. A progress note, dated 5/23/23 at 11:30 a.m., indicated Resident F was showing signs and symptoms of not receiving the dialysis treatments. A progress note, dated 5/23/23 at 2:00 p.m., indicated Resident F was transported to the emergency department via ambulance. A progress note, dated 5/23/23 at 11:11 p.m., Resident F returned from the emergency department. Resident F did not receive a dialysis treatment. Resident F did not receive a dialysis treatment on 5/22/23, 5/23/23, and 5/24/23. Resident F was transferred to another facility to receive routine dialysis treatments on 5/25/23.			

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MAJESTIC CARE OF SOUTHPORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227

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	4. During an interview on 5/27/23 at 8:35 a.m., the MDS Coordinator indicated Resident G missed dialysis treatments. Resident G's normal schedule for dialysis treatments was on Mondays, Wednesdays, and Fridays. The clinical record of Resident G was reviewed on 5/30/23 at 10:00 a.m. The diagnoses included, but were not limited to, acute kidney failure, chronic respiratory failure, and heart failure. A Brief Interview For Mental Status (BIMS), dated 5/18/23, indicated Resident G was severely cognitively impaired. The Physician's orders included, but were not limited to: Hemodialysis 3 times weekly Monday through Friday, initiated on 5/15/23 and discontinued on 5/25/23. A Physician's progress note, dated 5/25/23 at 4:37 p.m., indicated Resident G had a half run of hemodialysis completed on 5/18/23. Resident G had not been dialyzed since 5/18/23. Today Resident G feels positive for cough and feels getting fluid up with heavy breathing and having back pain. Resident G had fluid overload with acute respiratory failure due to last half run hemodialysis was on 5/18/23. Will plan for transfer to the emergency department for further management. Resident G did not receive dialysis treatments on 5/19/23, 5/22/23, and 5/24/23. 5. During an interview on 5/27/23 at 8:35 a.m., the MDS Coordinator indicated Resident H missed dialysis treatments due to not having an appointment available. Resident H was transferred			

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	to another facility to receive routine dialysis treatments. The clinical record for Resident H was reviewed on 5/27/23 at 10:06 a.m. The diagnoses included, but were not limited to, heart failure, end stage renal disease, and acute respiratory failure. A Quarterly MDS assessment, dated 4/5/23, indicated Resident H was cognitively intact. The Physician's orders, included, but were not limited to: Hemodialysis 5 times a week Monday through Friday, initiated on 1/16/23 and discontinued on 5/25/23. Resident H did not receive dialysis treatments on 5/19/23, 5/22/23, 5/23/23, and 5/24/23. Resident H was discharged to another facility to receive routine dialysis, on 5/25/23. 6. During an interview on 5/27/23 at 8:35 a.m., the MDS Coordinator indicated Resident J missed dialysis treatments. Resident J was discharged to another facility to receive routine dialysis treatments. The clinical record for Resident J was reviewed on 5/30/23 at 9:45 a.m. The diagnoses included, but were not limited to, dependence on renal dialysis and acute respiratory failure. A BIMS, dated 5/18/23, indicated Resident J was severely cognitively impaired. The Physician's orders included, but were not limited to: Hemodialysis Monday through Friday, initiated			

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	on 5/15/23 and discontinued on 5/25/23. Resident J did not receive a dialysis treatment on 5/22/23, 5/23/23, and 5/24/23. Resident J was discharged to another facility on 5/24/23. 7. During an interview on 5/27/23 at 8:35 a.m., the MDS Coordinator indicated Resident K missed dialysis treatments because he had a tracheostomy (a tube that enters the front of the neck and into the windpipe to allow air to fill the lungs). Resident K was discharged to another facility to receive routine dialysis treatments. The clinical record for Resident K was reviewed on 5/30/23 at 9:13 a.m. The diagnoses included, but were not limited to, heart failure and end stage renal disease. A Quarterly MDS assessment, dated 4/10/23, indicated Resident K was cognitively intact. The Physician's orders included, but were not limited to: Hemodialysis 3 times a week on Mondays, Wednesdays, and Fridays, initiated on 4/7/23. A progress note, dated 5/19/23 at 3:47 p.m., indicated Resident AK's wife was notified the facility was not able to accommodate dialysis due to Resident AK having a tracheotomy. Resident AK would have to go to another facility for dialysis. Resident AK did not receive a dialysis treatment on 5/22/23 and 5/24/23. Resident AK discharged to another facility on			

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	5/25/23. During an interview on 5/27/23 at 8:35 a.m., the MD'S Coordinator indicated dialysis was not provided in the facility after 5/19/23. On 5/26/23 at 11:30 a.m., the Administrator provided a copy of a facility policy, titled Dialysis Care, dated 7/2020, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will assure that each resident that requires dialysis services, receives such services that are consistent with the professional standards. The Immediate Jeopardy, that began on 5/22/23, was removed on 5/27/23 when the facility inserviced the staff on dialysis care, adverse effects of missed dialysis treatments, and implemented a plan for dialysis residents when transportation does not arrive, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaint IN 00409435 3.1-37(a)			
F 9999 Bldg. 00	3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food service supervisor, during the	F 9999	**It is the practice of this provider to ensure that all required events are reported to the Indiana Department of Health. What corrective action will be**	06/16/2023

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	same hours, The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144) of the division. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to report to the state health department when a resident fell out of his wheelchair, on the facility bus, and fractured both legs. (Resident D) Finding includes: During an interview on 5/30/23 at 12:12 p.m., Resident D indicated the Maintenance Director was driving the facility bus when Resident D was being transported. The Maintenance Director stopped the bus and Resident D fell forward out of his wheelchair and the wheelchair moved forward. Resident D's legs were pinned between his motorized wheelchair and the bus seat. He indicated his wheelchair wasn't secured to the floor. Resident D indicated the Maintenance Director was in a hurry. Resident D indicated he didn't put his wheelchair seat buckle on because he was used to being strapped in once on the bus. Resident D thought his right leg "looked like the bone was going to come out." The Maintenance Director did not secure Resident D's motorized		**accomplished for those residents found to have been affected by the deficient practice?** Resident D was assessed and had no adverse effects related to deficient practice. MD made aware of deficient practice. No new orders or changes to plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents that travel on the facility bus/van have the potential to be affected by deficient practice. ED/Designee completed facility audit to ensure that all required bus incidents/events have been reported. No other residents or events were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? RVP/Designee will complete in-service/education for all staff on requirement for reporting. ED/Designee will complete weekly audit to ensure that all required incidents/events have been reported to ISDH as needed. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	wheelchair to the bus floor. The Maintenance Director did not put the seat belt on Resident D. During an interview on 5/30/23 at 12:49 p.m., the Maintenance Director indicated Resident D was sitting in his motorized wheelchair while being transported in the facility bus. The Maintenance Director was driving and came to a stop. Resident D "flipped" out of the wheelchair. This was not the Maintenance Director's first time driving the facility bus to transport residents. The clinical record for Resident D was reviewed on 5/30/23 at 3:13 p.m. The diagnoses included, but were not limited to, paraplegia and post-traumatic stress disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 4/12/23, indicated Resident D was cognitively intact. A hospital progress note, dated 12/29/22 at 6:19 p.m., indicated Resident D presented to the emergency department after he fell forward from his wheelchair because he was not secured in the transport van. A hospital progress note, dated 1/1/23 at 11:16 a.m., indicated Resident D sustained a right tibial shaft fracture (right lower leg), a left femur fracture (left upper leg), and a left tibial fracture just below the knee. On 5/31/23 at 3:00 p.m., a review of The Long Term Care Abuse and Incident Reporting Policy, dated 12/8/22, was completed. The review indicated the facilities are required to report any major accident that results in a fracture.		ED/ designee will complete the May Complaint QAPI tool weekly x 4, bi-weekly x 2, and monthly x 4 and then at least quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. By what date the systemic change will be completed? June 16, 2023	