	T OF HEALTH AND HU					FOI	TED: 11/19/2024 RM APPROVED B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	l í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/23/2024	
	PROVIDER OR SUPPLIE			300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000 Bldg. 00	Licensure Survey. Investigation of Co IN00434180, IN00 IN00439138, IN00 and IN00444172. Complaint IN0043 related to the alleg Complaint IN0043 the allegations are Complaint IN0043 related to the alleg F921.	5618 - Federal/state deficiencies ations are cited at F804. 6115- No deficiencies related to cited. 6796 - Federal/state deficiencies ations are cited at F804. 9138 - Federal/state deficiencies ations are cited at F804 and	F 00	000	Please accept this response a our credible allegation of compliance for Majestic Care Lafayette. We respectfully request a des review for this plan of corrections.	of k	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Complaint IN00441551 - Federal/state deficiencies related to the allegations are cited at F887.

Complaint IN00443626 - Federal/state deficiencies

Complaint IN00444172 - No deficiencies related to

related to the allegations are cited at F755.

the allegations are cited.

(X6) DATE

TITLE

Brian Lessley 11/13/2024

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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/23/2024
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Survey dates: Octob 2024	per 16, 17, 18, 21, 22 and 23,			
	Facility number: 00 Provider number: 1 AIM number: 1002	55243			
	Census Bed Type: SNF/NF: 92 Total: 92				
	Census Payor Type: Medicare: 7 Medicaid: 77 Other: 8 Total: 92	:			
	These deficiencies raccordance with 410	reflect State Findings cited in 0 IAC 16.2-3.1.			
	Quality review was 2024.	completed on October 28,			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b) Resident Rights/E				
3 ***	failed to ensure care completed by a part to the resident's pre-	and record review, the facility e given to a resident was not icular staff member according ference for 1 of 1 resident nt rights. (Resident D)	F 0550	br1. RN 7 immediately remove from resident D care on 10/22/2024.br3. Resident D's careplan was updated on preferences on 10/23/2024 by SSD.br1. All residents have the potential to be effected by this	/ ne
	During an interview Resident D indicate	d he did not want RN 7 to take had informed management taking care of him.		potential to be affected by this deficient practice.brWhat measures will be put in place what systemic changes will be made to ensurethat the deficience practice does not recur:brAll swill be educated upon hire,	and e ent

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Event ID:

MPE811

Facility ID: 000147

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	T OF PERIODE	_			OMB NO. 0938-039
	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155243	B. WING		10/23/2024
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD NDY HILL DR	-
MAJEST	IC CARE OF LAFA	YETTE		ETTE, IN 47905	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	During an interview	y, on 10/22/24 at 10:12 a.m., the		quarterly, and as needed.brHe	ow
	Director of Nursing	(DON) indicated she was		the corrective actions will be	
	aware RN 7 was no	t supposed to be taking care of		monitored to ensure the defici	ient
	Resident D. She wa	s assigned to the hall often but		practice will notrecur:brThe Q	API
	was not to take care	of Resident D.		committee will review monthly	/ and
				if 100% compliance is not	
	The clinical record	for Resident D was reviewed		achieved an actionplan will be)
	on 10/17/24 at 3:29	p.m. The diagnoses included,		developed.	
		l to, schizoaffective disorder,		F550	
	bipolar type, anxiet	y disorder and problem related			
	to unspecified psyc	hosocial circumstances.			
				What corrective actions will be	е
	A Medication Adm	inistration Record (MAR)		accomplished for those reside	ents
	indicated RN 7 adm	ninistered Resident D's		found to have been affected b	by the
	medications on 9/1,	9/3, 9/4, 9/6, 9/7, 9/8, 9/9, 9/11,		deficient practice:	
	9/20, 9/21, 9/22, 9/2	23, 10/5, 10/6, 10/12, and		1. RN 7 immediately removed	I from
	10/16/24.			resident D care on 10/22/2024	4.
				2. RN 7 inserviced on 10/22/2	2024
	A vitals tab indicate	ed RN 7 obtained vital signs		on Resident Rights by DNS.	
	for Resident D on 9	/1, 9/3, 9/4, 9/6, 9/8, 9/9, 9/11,		3. Resident D's careplan was	
	9/20, 9/21, 9/22, 9/2	23, 10/5, 10/6, 10/12, and		updated on preferences on	
	10/16/24.			10/23/2024 by SSD.	
				How other residents having th	ne
	1	y, on 10/23/24 at 10:00 a.m., LPN		potential to be affected by the	
		lent had been expressing he		same deficient practice will be	
		to take care of him ever since		identified and what corrective	
	she started working	here.		action will be taken:	
				All residents have the poter	
	_	y, on 10/23/24 at 11:25 a.m., the		to be affected by this deficient	t
		d appear as if RN 7 had been		practice.	
	taking care of the re	esident.		2. All residents that reside in t	the
				facility were reviewed for	
		eled "RESIDENT RIGHTS,"		preferences by the SSD on	
		ceived from the Clinical		11/7/2024.	
		4 at 3:03 p.m., indicated "The		What measures will be put in	
	_	nt to and the facility must		place and what systemic char	
	_	ate resident self-determination		will be made to ensure that th	
		resident choice, including but		deficient practice does not rec	cur:
		ne resident has the right to		All staff were educated on	
	choose activities, so	chedules (including sleeping		Resident Rights on 11/9/2024	by

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/23/2024
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	health care services interests, assessmen applicable provision	health care and providers of consistent with his or her tts, and plan of care and other as of this part" to Complaint IN00430580.		the DNS/Designee. All staff will be educated upon hire, quarterly, and as needed 2. IDT rounds will be conducted daily to ensure residents preferences are updated as needed. How the corrective actions will monitored to ensure the deficit practice will not recur: Resident Preference/Resident Rights QAPI tool developed to ensure resident rights are beinfollowed. This will will be completed daily x 4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliant is not achieved an action plant be developed.	I. ed I be ent t o ng
F 0580 SS=D Bldg. 00	Based on interview failed to ensure staff Director and the resafter the resident ext of 1 resident reviews 1 of 1 resident reviews 1) Finding includes: During an interview Resident 81 indicated 10/19/24, she felt liget help. She had in	(Injury/Decline/Room, etc.) and record review, the facility if notified the Social Service ident's physician immediately pressed suicidal thoughts for ewed for notification. (Resident a, on 10/21/24 at 10:06 a.m., ed she told a nurse, on ke killing herself and wanted to creased feelings of depression is very upset nothing was	F 0580	F580 What corrective actions will be accomplished for those reside found to have been affected be deficient practice: 1. Resident 81 was immediate seen by SSA on 10/21/2024. 2. SSA immediately reached of to psych services and comple a telehealth visit on 10/21/2023. Medical director came to building on 10/21/2024 and completed an evaluation for resident 81.	ents by the ely but ted

Ţ.		X1) PROVIDER/SUPPLIER/CLIA	ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPLE	
		155243	B. W	ING		10/23/2	2024
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	done.				Psych services discontinue		
					minute checks on 10/21/2024	for	
		for Resident 81 was reviewed			resident 81.		
		25 a.m. The diagnoses included,			How other residents having the		
		d to, major depressive disorder			potential to be affected by the		
	and general anxiety	у.			same deficient practice will be		
		1 . 1 . 4 . (2			identified and what corrective		
		r, dated 5/18/24, indicated to			action will be taken:		
		(mg) of duloxetine delayed			1. All residents with suicidal		
	release for depressi	ion daily.			ideation/thoughts have the		
		1 4 1 10/2/24 : 1: 4 14			potential to be affected by this	S	
		r, dated 10/2/24, indicated to			deficient practice.	41	
		pirone for anxiety three times a			2. All residents that reside in		
	day.				facility were assessed for suit		
	A core plan dated	7/23/24, indicated the resident			ideation based on diagnosis a PHQ9 on 10/21/2024.	anu	
	_	opic medication. Interventions			What measures will be put in		
		not limited to, monitor for side			place and what systemic char		
	· ·	essant medication and suicidal			will be made to ensure that th	-	
	thoughts.	essant medication and surcidar			deficient practice does not re-		
	inoughts.				All staff were educated on	oui.	
	During an interview	w, on 10/21/24 at 11:18 a.m., the			10/22/2024 by DNS/Designed	e to	
	_	istant (SSA) indicated the			immediately report any suicid		
		er and indicated she wanted			ideation to charge nurse, DNS		
	help.				SSD, resident's representativ		
	'				and physician. All staff will be		
	During an interview	w, on 10/21/24 at 11:21 a.m., the			educated upon hire, quarterly		
	_	was notified, at 11:00 a.m., by			as needed.	•	
	the resident she had	d suicidal thoughts over the			2. All nursing staff were educ	ated	
	weekend, and she h	nad told her nurse. The			on 10/22/2024 by DNS/Desig		
	procedure when a r	resident voiced suicidal			to document the resident's		
	thoughts was to pu	t them on 15-minute checks			mood/behaviors, as well as th	ne	
	and to immediately	call the Director of Nursing			actions taken in the medical		
	(DON) and SSA. T	The DON and SSA were not			record. All staff will be educat	ted	
	notified until 10/21	/24 at 11:00 a.m.			upon hire, quarterly, and as		
					needed.		
	_	w, on 10/21/24 at 11:28 a.m., the			How the corrective actions wi	ll be	
	Executive Director	asked the SSD if the resident			monitored to ensure the defic	ient	
	told staff about the	incident and the SSA			practice will not recur what qu	uality	
	indicated the reside	ent told a nurse.			assurance program will be pu	ıt into	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMF	E SURVEY PLETED 3/2024
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP INDY HILL DR 'ETTE, IN 47905	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	DON indicated she voiced suicidal thor resident had increase when a resident voicall the DON and Start a plan. She she was not. There was no docur SSA or physician was uicidal thoughts. A current policy, time Ideations," dated 1/4 Clinical Support Not indicated "All stareport any suicidal charge nurse and far Immediately notify resident presents we or she isn't specific intentObjectively and behaviors, as we medical records" A current policy, time Condition/Physicial and received from the 10/16/24 at 3:30 p.1 notify the physicial resident/resident's resident's resident'resident's resident'resident's resident's residen	document the resident's mood rell as all actions taken, in the rell as all actions taken, in the relation of the resident's physical,		place: Behavior Managemer developed to insure p followed correctly, this completed daily x 4 w monthly for 6 months, quarterly thereafter by DNS/Designee. The QAPI committee monthly and if 100% o is not achieved an act be developed.	olicy is being s will be eeks, and the will review compliance	
F 0695 SS=D	483.25(i) Respiratory/Trach	eostomy Care and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155243	B. W	ING		10/23/	2024
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD NDY HILL DR		
MAJESTI		VETTE					
WAJEST	IC CARE OF LAFA	YEIIE		LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	Suctioning						
	Based on observation	on, interview and record	F 00	695	F695		11/09/2024
	review, the facility	failed to administer the correct			What corrective actions will be	•	
	amount of oxygen a	s ordered by the physician for			accomplished for those reside	nts	
	1 of 1 resident revie	ewed for respiratory care.			found to have been affected b	y the	
	(Resident 5)				deficient practice:		
					1. Resident 5 was immediately	y	
	Finding includes:				evaluated by nursing on		
					10/18/2024 and oxygen satura	ation	
	During an observati	on, on 10/16/24 at 11:15 a.m.,			corrected.		
		concentrator (a device used			2. Resident 5 was monitored		
	to provide suppleme	ental oxygen therapy) was set			beginning on 10/18/24 x3 days	s for	
	on 2 liters per minu	te (L).			respiratory distress.		
					3. Nursing notified NP on		
		on, on 10/17/24 at 9:57 a.m.,			10/18/2024 of oxygen saturati	on	
	Resident 5's oxygen	concentrator was set on 2.5L.			and received no new orders for	or	
					resident 5.		
		on, on 10/18/24 at 11:31 a.m.,			How other residents having th		
	Resident 5's oxygen	concentrator was set on 2L.			potential to be affected by the		
					same deficient practice will be	;	
		for Resident 5 was reviewed on			identified and what corrective		
	_	m. The diagnoses included, but			action will be taken:		
		end stage renal disease,			All residents that have an		
		failure with hypoxia, chronic			oxygen order have the potenti	al to	
	_	ary disease, chronic kidney			be affected by this deficient		
	-	oulmonary disease, chronic			practice.		
		personal history of malignant			2. All residents in the facility w		
	-	ites of lip, oral cavity and			oxygen orders were assessed	for	
		ny status, and dependence on			correct oxygen settings on		
	renal dialysis.				10/18/2024.		
					What measures will be put in		
	_	7/12/23, indicated the resident			place and what systemic chan	-	
	• • •	apy. Interventions included,			will be made to ensure that the		
		l to, observe for signs of			deficient practice does not rec	ur:	
		and administer oxygen per			1. All staff were educated on		
	order.				following physician's orders fo		
		1 . 1 . (01/04			oxygen settings on 11/9/2024	-	
		, dated 6/21/24, indicated the			the DNS/Designee. All staff w		
	resident was to rece	ave 1L of oxygen			educated upon hire, quarterly,	and	
	continuously.				as needed.		

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11/19/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155243 B. WING 10/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 WINDY HILL DR MAJESTIC CARE OF LAFAYETTE LAFAYETTE, IN 47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE How the corrective actions will be During an interview, on 10/18/24 at 11:39 a.m., monitored to ensure the deficient QMA 4 indicated the resident's oxygen practice will not recur what quality concentrator was on 2L. She was unsure of the assurance program will be put into resident's ordered liter flow. place: Respiratory QAPI tool developed During an interview, on 10/18/24 at 11:43 a.m., LPN to monitor oxygen settings 3 indicated the resident's order was for 1L. compared with PCC orders, along with supplies and storage, this be During an interview, on 10/23/24 at 11:23 a.m., the completed daily x4 weeks, Director of Nursing (DON) indicated Resident 5's monthly for 6 months, and oxygen liter flow was previously at the wrong quarterly thereafter by the setting and staff should have followed the DNS/Designee. physician's orders. The QAPI committee will review monthly and if 100% compliance A current policy, titled "Oxygen Administration," is not achieved an action plan will dated 12/12/23 and received from the Clinical be developed. Support on 10/18/24 at 2:05 p.m., indicated "...Oxygen is administered to residents who need it, consistent with professional standards of practice...Oxygen is administered under orders of a physician...." 3.1-47(a)(6) F 0755 483.45(a)(b)(1)-(3) SS=D Pharmacy Bldg. 00 Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility F 0755 F755 11/09/2024 failed to ensure staff accurately documented on What corrective actions will be the narcotic count sheets, documented medication accomplished for those residents administration in the Medication Administration found to have been affected by the Record, and properly documented the disposal of deficient practice: medication for 1 of 2 residents reviewed for pain 1. DNS completed audit for management. (Resident E) resident E's narcotic count sheet and electronic medical record on Findings include: 10/22/2024. 2. LPN 9 was inserviced on The clinical record for Resident E was reviewed on 10/22/2024 by the DNS on

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10/16/24 at 11:46 a.m. The diagnosis included, but

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narcotic disposal policy.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155243	B. W	ING		10/23/	/2024
		1		STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			NDY HILL DR		
MAJEST	IC CADE OF LAFA	VETTE			ETTE, IN 47905		
IVIAJEOI	IC CARE OF LAFA	.TETTE		LAFAYI	ETTE, IN 47900		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		, chronic pain syndrome and			3. Nurse manager was		
	non-pressure chron	ic ulcer of foot.			immediately educated on		
					10/22/2024 by the DNS that the	ne	
	_	ntries were documented in the			waste/disposal of controlled		
	month of August on a narcotic medication count				medication are done in the		
	1	ne (a narcotic medication to			presence of the nurse and a		
	treat pain) 5 milligr	rams:			witness who also signs the		
					disposition sheet.		
		8/3/24 at 5:00 a.m., indicated			How other residents having th		
	one Oxycodone wa	s administered.			potential to be affected by the		
					same deficient practice will be	;	
		was not documented in the			identified and what corrective		
	Medication Admini	istration Record (MAR).			action will be taken:		
					All residents with orders for		
	2. An entry, dated 8/3/24 at 6:20 p.m., indicated				controlled medication have the		
	one Oxycodone wa	s administered.			potential to be affected by this	;	
					deficient practice.		
		was not documented in the			What measures will be put in		
	MAR.				place and what systemic char	-	
	2 4	2/2/24 + 2.15			will be made to ensure that the		
	1	8/3/24 at 3:15 p.m., indicated			deficient practice does not rec		
	one Oxycodone wa	s administered.			All nursing staff were education in the staff were education.		
		. 1 1			on correctly documenting nard		
		was not documented in the			medication on the count shee		
		line strike through the entry,			in the electronic medical recor		
		ed by the nurse. The			11/9/2024 by the DNS/Design		
		not indicate 2 nurses'			All nursing staff will be educat	ea	
		cumented to show the sted and the medication was			upon hire, quarterly, and as		
		the MAR indicating the			needed.	atad	
	medication had bee	_			2. All nursing staff were educa	aleu	
	medication had bee	n administred.			on 11/9/2024 by the	'c	
	On 8/3/24 two entr	ries were out of chronological			DNS/Designee that two nurse signatures are required to was		
		s made for at 6:20 p.m., with a			narcotic medication. All nursing		
	subsequent entry m	_			staff will be educated upon hir	-	
	Saosequent entry III	шие и 3.13 р.ш.			quarterly, and as needed.	С,	
	During an interview	v, on 10/22/24 at 11:21 p.m., the			How the corrective actions wil	l he	
	_	of Nursing (ADON) indicated if			monitored to ensure the defici		
		on needed to be wasted, two			practice will not recur what qu		
		the narcotic count sheet, and			assurance program will be pu	-	
	I marbeb would bight	are marcone count sheet, and	ı		Lassarance program will be pu	LIIIO	I

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/23/2024	
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR 'ETTE, IN 47905	
	SUMMARY: (EACH DEFICIEN REGULATORY OR the medication wou 4. An entry, dated 8 one Oxycodone was: This administration MAR. 5. A physician orde and end date of 8/28 Oral Tablet 10 mg, hours as needed for use two 5 milligram The MAR indicated milligrams was adm The documentation indicated, on 8/21/2 5 milligram was add incorrect documents During an interview ADON indicated th documented the am b. The following en month of Septembe count sheet for Oxy 1. An entry, dated 9 one Oxycodone was	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION Id be destroyed. 1/4/24 at 7:14 p.m., indicated a administered. was not documented in the r, with a start date of 8/21/24 8/24, indicated Oxycodone HCI give 1 tablet by mouth every 6 chronic pain for 7 days, may a tabs until 10 milligrams arrived. 1, on 8/21/24, Oxycodone 10 ninistered. on the narcotic count sheet 4 at 11:52 a.m., one Oxycodone ministered, indicating an ation of the amount given. 7, on 10/22/24 at 1:15 p.m., the e nurse incorrectly ount given. tries were documented in the r on the narcotic medication codone 5 milligrams: 1/14/24 at 5:20 p.m., indicated	300 W	INDY HILL DR	o to have AR, 4 , and iew ince
		1/18/24 at 10:19 a.m., indicated s administered and the was one.			

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155243	B. W	ING		10/23	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
			-	<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	•	0/18/24 at 5:00 p.m., indicated					
		s administered and the					
	remaining quantity was one.						
	The new cinine arres	atity do assessment ad on this auture					
	The remaining quantity documented on this entry was incorrect.						
	4 An entry dated 9	0/18/24 at 5:00 p.m., indicated					
		s administered and the					
	remaining quantity						
	remaining quantity	was zero.					
	This entry did not h	ave a nurse signature.					
	Duning on interview	v, on 10/22/24 at 3:00 p.m., the					
		g (DON) indicated she was					
	_	ere signing out the medication					
	on the medication c						
		lministration in the MAR.					
	documenting the ad	ininistration in the WAK.					
	c. Review of a narc	otic count sheet for a					
		ation order of Oxycodone 10					
		ed 28 doses remained and were					
	destroyed on 5/30/2						
	,						
	The documentation	indicated LPN 9 signed the					
		emaining 28 doses on the					
	narcotic count shee	t and failed to obtain a witness					
	signature.						
	During an interview	v, on 10/22/24 at 11:21 p.m., the					
	ADON indicated w	hen a narcotic medication was					
	destroyed, the unit	manager and a nurse would					
	destroy the remaining	ng quantity, and both would					
	sign the disposition	sheet.					
	_	v, on 10/22/24 at 1:14 p.m., the					
		e disposition of remaining					
		ic count sheet, dated 5/30/24,					
		as not sure why the					
	disposition did not	have a witness signature. She					
			1				i

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER 155243	A. BUILI B. WING	DING	00	COMPL 10/23/	ETED
	PROVIDER OR SUPPLIER		3	300 WIN	DDRESS, CITY, STATE, ZIP COD IDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	witnessed the destrumedication and sign A current policy, tit Administration," da	eled "Medication ted 1/2/2024 and received by					
	"Sign MAR after A current policy, tit	led "Documentation of					
	and received by the indicated "A Nurs (where applicable) administered to eac medication administ (MAR)Administr	tration," last revised 4/2007 DON on 10/22/24 at 3:00 p.m., see of Certified Medication Aide shall document all medications h resident on the resident's tration record ation of medication must be liately after (never before) it is					
	last revised 4/2019 10/22/24 at 3:00 p.r complies with all la requirements related disposal, and documedicationUpon of are opened and sub- or partly administer and/or disposal of c	and received by the DON on m., indicated "The facility ws, regulations, and other d to handling, storage, mentation of controlled dispositionMedication that sequently not given (refused red) are destroyed. Waste ontrolled medication are done me nurse and a witness who sition sheet"					
	This citation relates 3.1-25(e)(2)	to Complaint IN00443626.					
	3.1-25(o) 3.1-25(s)(8)						

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		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155243	B. W	ING		10/23/	/2024
N	NOTHER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAY	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
F 0791 SS=D	483.55(b)(1)-(5)	Dantal Omiaa in NE-					
	Routine/Emergend	cy Dental Srvcs in NFs					
Bldg. 00	Raced on observation	on, interview and record	F 0	701	F791		11/09/2024
		failed to ensure a resident was	FU	/91	What corrective actions will be	2	11/09/2024
	1	d dental services for 1 of 1			accomplished for those reside		
		or dental services. (Resident 8)			found to have been affected b		
	1051delli 16 viewed ik	or definition (resident 0)			deficient practice:	y u iC	
	Finding includes:				SSA immediately made an		
					appointment, on 10/21/2024, v	with	
	During an observati	on, on 10/16/24 at 11:27 a.m.,			Advantage Dentures for Resid		
	Resident 8 had miss				8.		
					2. Resident 8 seen in office fo	r	
	During an interview	y, on 10/16/24 at 11:27 a.m.,			evaluation and treatment on		
	_	d she wanted new dentures.			10/30/2024.		
	She previously lost	a large amount of weight, and			How other residents having th	е	
	her old dentures no	longer fit. She indicated she			potential to be affected by the		
	would like to get ne	w ones, but staff had not			same deficient practice will be		
	helped her to find a	provider in her insurance			identified and what corrective		
	network when she a	sked for assistance.			action will be taken:		
					1. All residents with dental nee	eds	
		for Resident 8 was reviewed on			have the potential to be affect	ed	
	_	n. The diagnoses included, but			by this deficient practice.		
		type 2 diabetes mellitus,			2. Audit performed on 10/21/2		
		disease, chronic diastolic heart			for all current residents that ha		
	failure, post-trauma				been seen by Aria dental in th	е	
	hyperlipidemia, and	age-related physical debility.			last 3 months for potential		
					deficient practice.		
		dated 9/19/22, indicated			3. Audit performed on 10/21/2		
	I	seen by a podiatrist, dentist,			for all residents in the facility for	or all	
	-	ogist, psychiatrist, and			desired denture services.		
	psychologist.				What measures will be put in		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	V/11/22 : 1: 4 1B : 1 4 2			place and what systemic chan		
		7/11/22, indicated Resident 8			will be made to ensure that the		
		and dental health problems due			deficient practice does not rec		
	1	(having missing teeth).			1. SSD/SSA were educated of		
		led, but were not limited to,			11/9/2024 by DNS/Designee t		
		nents for dental care,			after each dental evaluation in		
	uansportation as ne	eded and as ordered.			facility, the SSD/SSA is to revi	iew	
	ı				r an illanteoons		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/23/2024 155243 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 WINDY HILL DR MAJESTIC CARE OF LAFAYETTE LAFAYETTE, IN 47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A care plan, revised on 9/30/24, indicated 2. All staff were educated on Resident 8 needed assistance with activities of 11/9/2024 on notifying social daily living. Interventions included, but were not services if resident is limited to, staff to assist and encourage oral care needing/requesting dental twice daily. services. How the corrective actions will be A dental note, dated 7/31/23, indicated Resident 8 monitored to ensure the deficient had no teeth or dentures present. Her oral tissue practice will not recur what quality was within normal limits and the resident wanted assurance program will be put into dentures made. place: Dental QAPI tool developed to A dental note, dated 3/12/24, indicated Resident 8 ensure all dental needs are met. wanted new upper and lower complete dentures. this will be completed daily x4 weeks, monthly for 6 months, and A dental note, dated 8/7/24, indicated Resident 8 quarterly thereafter by the was fully edentulous with no removable DNS/Designee. appliances present. The resident stated she would The QAPI committee will review like dentures made. Her oral tissue was monthly and if 100% compliance generalized healthy with no significant findings is not achieved an action plan will on visual exam. be developed. During an interview, on 10/21/24 at 11:20 a.m., the Social Services Assistant (SSA) indicated she did not know Resident 8 wanted dentures. During an interview, on 10/22/24 at 11:23 a.m., the Director of Nursing (DON) indicated it was the social services' responsibility to follow up with any recommendations from dental providers. During an interview, on 10/23/24 at 10:50 a.m., the DON indicated she was unsure why it had taken so long to address Resident 8's request for dentures. A current policy, titled "Dental Services," dated 1/2/24 and received from the DON on 10/23/24 at 1:31 p.m., indicated "...It is the policy of this facility to assist residents in obtaining

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routine...and emergency dental care...Oral care and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155243 B. WING 10/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 WINDY HILL DR MAJESTIC CARE OF LAFAYETTE LAFAYETTE, IN 47905

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	denture care shall be provided in accordance with			
	identified needs and as specified in the plan of			
	careReferrals todental provider shall be made			
	as appropriateThe facility will, if necessary or			
	requested, assist the resident with making dental			
	appointments and arranging transportation to and			
	from the dental services location"			
	3.1-24(a)(3)			
	3.1-24(b)			
F 0804	483 60(d)(1)(2)			
SS=D	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer			
Bldg. 00				
Diag. 00	Temp Based on observation and interview, the facility	E 0004	F804	11/00/2024
	failed to ensure food was served at a safe and	F 0804		11/09/2024
			What corrective actions will be	
	appetizing temperature for 1 of 1 room tray tested		accomplished for those residents	
	for temperatures. (100 hall)		found to have been affected by the	
	Finally as in dealer		deficient practice?	
	Findings include:		1. Resident E was interviewed for	
	Device intermines 10/16/24 - t 10/54		food preferences by the dietary	
	During an interview, on 10/16/24 at 10:54 a.m.,		manager on 10/16/2024.	
	Resident E indicated the food was usually cold,		2. Resident 48 was interviewed for	
	especially for room trays.		food preferences by the dietary manager on 10/16/2024.	
	During an interview, on 10/16/24 at 2:53 p.m.,		3. The ravioli temped at 116	
	Resident 48 indicated the food was cold a lot.		degrees F was immediately	
			exchanged for another tray	
	During a resident council meeting, on 10/18/24 at		temped at over 120 degrees F.	
	2:35 p.m., the resident council indicated the food		How other residents having the	
	was cold, even when eating in the dining room.		potential to be affected by the	
			same deficient practice will be	
	During an observation and interview, on 10/16/24		identified and what corrective	
	at 12:40 p.m., a lunch tray was chosen to get food		action(s) will be taken.	
	temperatures. The ravioli temped at 116 degrees.		All residents have the potential	
	The dietary manager indicated hot foods should		to be affected by the alleged	
	be served at least 120 degrees or above.		deficient practice.	
			For all residents with an	
	A facility policy, titled "Food: Quality and		unsatisfactory temperature, the	
	Palatability," last revised on 2/2023 and received		food will be replaced or reheated	
	r arataomity, last revised on 2/2023 and received		l lood will be replaced of refleated	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/23/2024			ETED		
	PROVIDER OR SUPPLIER			300 WIN	DDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF from the Director o p.m., indicated "F methods that conser appearance. Food w served at a safe and temperaturePrope temperature as dete ensure resident's saf risk for scalding and	r (safe and appetizing) should be at the appropriate rmined by the type of food to cisfaction and minimizes the d burns" to Complaints IN00435618,	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIMENCED TO THE AP	to onges ecur. were and res. in ed for d at ered or d with et el d to within daily ter by iew not	(X5) COMPLETION DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION X	(3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155243	B. WING 10/23/2024			
			CTD FFT	ADDRESS COMMA STATE TIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD NDY HILL DR		
MA IEST	IC CARE OF LAFA	VETTE		ETTE, IN 47905		
MAJEST		TETTE	LAFAT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
F 0842	483.20(f)(5), 483.					
SS=D	Resident Records	s - Identifiable Information				
Bldg. 00						
		and record review, the facility	F 0842	F842		11/09/2024
		mood and behaviors in the		What corrective actions will be		
		cords (EHR) for 1 of 1 resident		accomplished for those resident		
	with suicidal thoug	hts. (Residents 81)		found to have been affected by	the	
				deficient practice:		
	Finding includes:			1. Unit manager, nurse, and soc		
				services immediately educated	on	
	_	v, on 10/21/24 at 10:06 a.m.,		documenting resident's		
		ed she told a nurse, on		behaviors/moods in the medical		
	10/19/24, she felt like killing herself and wanted to			record on 10/21/2024 by the DN	IS.	
	get help. The reside	ent was very upset.		How other residents having the		
		6 B :1 :01		potential to be affected by the		
		for Resident 81 was reviewed		same deficient practice will be		
		25 a.m. The diagnoses included,		identified and what corrective		
		d to, major depressive disorder		action will be taken:		
	and general anxiety	7.		1. All residents have the potential	al	
	A physician's order	, dated 5/18/24, indicated to		to be affected by this deficient		
		(mg) of duloxetine delayed		practice.		
	release for depressi	·		What measures will be put in place and what systemic change	20	
	release for depressi	on dany.		will be made to ensure that the	55	
	A physician's order	, dated 10/2/24, indicated to		deficient practice does not recur		
		irone for anxiety three times a		All nursing staff were educate		
	day.	mone for anxiety times times a		on 10/22/2024 by DNS/Designe		
	day.			to document resident's	C	
	There was nothing	documented in the EHR about		mood/behaviors, as well as the		
		eling Resident 81 was having.		actions taken in the medical		
	are moughts and re	oning resident of was naving.		record for a resident with suicida	al	
	During an interview	v, on 10/21/24 at 11:21 a.m., the		ideation. All staff will be educate		
	_	g (DON) indicated the staff		upon hire, quarterly, and as	,,,	
		ne resident's mood and		needed.		
		dical records and nothing was		How the corrective actions will be	ne .	
	charted.	and nothing that		monitored to ensure the deficier		
				practice will not recur what quali		
	A current policy, ti	tled "Suicidal Thoughts &		assurance program will be put in	-	
	rj, •.		1	, a a e. e grann nim bo pat n		i e

Ideations," dated 1/2/24 and received from the

Clinical Support Nurse on 10/21/24 at 10:16 a.m.,

Behavior Management QAPI

place:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED			
		155243	B. WING					
			CTREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIEF	₹		NDY HILL DR				
MAJEST	IC CARE OF LAFA	YETTE		LAFAYETTE, IN 47905				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
		ff members will immediately		developed to ensure SI policy				
		ideation to the resident's		procedures are being followed				
	-	cility social worker. the resident's physician if the		will be completed daily x 4 we	eks,			
		ith suicidal ideation, even if he		monthly for 6 months, and				
	or she isn't specific			quarterly thereafter by the DNS/Designee.				
	_	document the resident's mood		The QAPI committee will revie	334/			
		rell as all actions taken, in the		monthly and if 100% complian				
	medical records"			1				
	incurcui records			is not achieved an action plan will be developed.				
	3.1-50(1)			be developed.				
F 0880	483 80(a)(1)(2)(4)	(e)(f)						
F 0880								
Bldg. 00	inicodon i reventi	on a control						
3	Based on observation	on, interview and record	F 0880	F880	11/09/2024			
		failed to ensure staff	1 0000	What corrective actions will be				
	-	inen down the hall correctly		accomplished for those reside	nts			
	_	(personal protective		found to have been affected by				
	equipment) into an	isolation room for 3 of 3		deficient practice:	,			
	randomly observed	staff. (CNA 12, 13 and 14)		1. CNA 12 was educated by the	ne			
				DNS on 10/18/2024, for handl	ing			
	Findings include			soiled linens.				
				2. CNA 13 and CNA 14				
	_	vation, on 10/18/24 at 11:45		immediately educated on				
	· ·	sing Assistant (CNA) 12 was		10/18/2024 on how and when	to			
		a large clear trash bag of dirty		wear PPE in an isolation room	, by			
		hall and placed the bag into		the DNS.				
	the soiled utility roo	om.		3. A chart review and resident				
		10/10/04		observation of Resident G				
		v, on 10/18/24 at 11:48 a.m.,		completed by DNS/designee				
		she should not drag dirty linen		revealed no negative outcome	:S			
	down the hall.			related to the cited deficient				
	During on intermier	y on 10/18/24 at 11:40 a m +ha		practice on 10/18/2024.				
	_	y, on 10/18/24 at 11:49 a.m., the g (DON) indicated the CNA was		How other residents having the	e			
		g dirty linen down the hall.		potential to be affected by the				
	not supposed to dra	g diffy lillell down the lian.		same deficient practice will be identified and what corrective				
	2 During an observ	vation, on 10/18/24 at 11:52		action will be taken:				
	_	as in Enhanced Barrier		All residents that are curren	tly			
	anni, resident o W	Lilliancea Daniel	i i	1 / III rosidonio indi ale cultett	uy j			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		155243	B. W	ING		10/23	/2024
		L		CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD NDY HILL DR		
MA IEST	IC CARE OF LAFA	VETTE			ETTE, IN 47905		
	COARL OF LAFA				_ _ 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	, ,	CNA 13 and CNA 14 was in			in enhanced barrier precautio		
		transferring the resident from			have the potential to be affect	ted	
		he bed. The CNAs were not			by this deficient practice.		
	-	touching the resident,			2. All residents have the pote		
	· ·	d. Licensed Practical Nurse			to be affected by the deficient		
	1 1	e room wearing gloves and saw			practice of handling soiled line	ens.	
		PPE. LPN 6 handed a gown			What measures will be put in		
		bag to CNA 13 and instructed			place and what systemic char	-	
	-	N 6 told CNA 14 she also			will be made to ensure that the		
	_	gown and gloves. CNA 14 put			deficient practice does not re	cur:	
	on her gown and did not tie the back of the gown.				1. All staff to be educated on 11/9/2024 for PPE and enhar	and .	
	The CNAs transferred the resident to the bed and						
	removed the mechanical lift pad. CNA 14 took the used mechanical lift pad and returned to the				barrier precautions on 11/9/24	4, by	
		vithout gloves. CNA 14			the DNS/Designee.	od for	
		illow under the resident's head			All staff education complete handling soiled linens on 11/9		1
		resident without wearing			by the DNS/designee.	7) 4 4	
	gloves.	estacht without wearing			How the corrective actions wi	ll he	
	510 (63.				monitored to ensure the defic		
	The clinical record	for Resident G was reviewed,			practice will not recur what qu		
		6 a.m. The diagnoses included,			assurance program will be pu	-	
		d to, end stage renal, major			place:		
		; and hypertension.			PPE QAPI developed to mon	itor	
	1	, J1			donning and doffing of PPE, t		
	A physician's order	r, dated 10/18/24, indicated EBP			will be completed daily x 4 we		
		nigh contact resident care			monthly for 6 months, and	,	
	activities.	-			quarterly thereafter by the		
					DNS/Designee.		1
	During an interview	v, on 10/18/24 at 12:03 a.m.,			Soiled linens QAPI developed	d to	
	CNA 14 indicated	she was not aware gloves were			ensure lines are being handle		
	needed when puttir	ng a pillow under the resident's			following policy and procedur		
	head.				this will be completed daily x4	1	
					weeks, monthly for 6 months,	and	
	-	v, on 10/18/24 at 12:07 a.m., LPN			quarterly thereafter by the		
		4 needed to put gloves on			DNS/Designee.		
		e resident and gowns need to			The QAPI committee will revi		
	be tied when provid	ding care.			monthly and if 100% complia		
					is not achieved an action plar	n will	1
		tled "Hand Hygiene," dated			be developed.		
	1/2/24 and provide	d by the Director of Nursing on					1

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243 NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF LAFAYETTE		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/23/2024	
		STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0883 SS=E Bldg. 00	10/23/22 at 2:04 p.i perform proper han prevent the spread of A current policy, the Control Program," entrance on 10/16/2 shall be performed facility's established All staff shall use performed to governing the use of care staff shall hand transport linens to perform the control of the cont	m., indicated "All staff will d hygiene procedures to of infection" Iteled "Infection Prevention & dated 1/2/24 and provided at 1/2, indicated "Hand hygiene in accordance with our d hand hygiene procedures. ersonal protective equipment established facility policy of PPELaundry and direct dle, store, process, and prevent spread of shall demonstrate competence in control practices"	TAG		DATE
	failed to ensure pne administered accord form for 4 of 7 resistent immunizations. (Reference of 10/21/24 at 9:56 but were not limited hematuria, cellulitistic diabetic chronic kid failure, chronic kid atrial fibrillation, and	and record review, the facility sumococcal vaccines were ding to the signed consent dents reviewed for esident I, 9, 41 and 84) and for Resident I was reviewed a.m. The diagnoses included, d to, sepsis, acute cystitis with s, type 2 diabetes mellitus with liney disease, acute kidney mey disease stage 3, paroxysmal memia, long term current use of al primary hypertension.	F 0883	F883 What corrective actions will be accomplished for those resider found to have been affected by deficient practice: 1. Audit performed facility wide all residents that are requesting receive the Pneumococcal vaccines on 10/22/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. All residents wanting the pneumococcal vaccine have the	nts / the e for g to

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potential to be affected.

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
		155243	B. WI	NG		10/23/	2024
				OTD FET	IDDREGG CHTV CT TO COP		
NAME OF F	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
MAJEST	IC CARE OF LAFA	YEIIE		LAFAYI	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	An informed conser	nt form for the pneumococcal			2. All resident requesting/qual	ify	
	vaccine, dated 8/19	/24, indicated the resident			for pneumococcal vaccine will	-	
	consented to receive	ing the vaccination.			receive them by 11/9/2024.		
					What measures will be put in		
	The electronic med	ical record did not include any			place and what systemic chan	iges	
	record of the admin	istration of the pneumococcal			will be made to ensure that the	-	
	vaccination after the	e signed consent form on			deficient practice does not rec	ur:	
	8/19/24.				1. IPSD will conduct consents		
					with all new admissions for		
	During an interview	y, on 10/22/24 at 10:11 a.m., the			pneumococcal vaccine within	72	
	Director of Nursing	(DON) indicated the			hours after admission and		
	immunization shoul	ld have been provided soon			schedule vaccine if warranted		
	after the consent was signed, but it had not been				2. IPSD will be in educated by	the	
	ordered or given.				DNS/ADNS on the pneumoco		
					vaccine with administration on		
	2. The clinical reco	rd for Resident 9 was reviewed			11/9/2024.		
	on 10/21/24 at 9:56	a.m. The diagnoses included,			3. IPSD will audit each admiss	sion	
	but were not limited	d to, chronic bronchitis,			within 72 hours post admission	n for	
	asthma, chronic kid	ney disease stage 3, other			the pneumococcal vaccination	١.	
	forms of acute ische	emic heart disease, chronic			This audit will occur with each		
	diastolic congestive	heart failure, anemia,			admission x6 months. Finding	s to	
	unspecified right bu	andle-branch block (disruption			be submitted to the Executive		
	of the heart's electri	cal signal to the right side of			Director.		
	the heart), essential	primary hypertension, and			How the corrective actions will	l be	
	obesity.				monitored to ensure the defici-	ent	
					practice will not recur what qu	ality	
		nt form for the pneumococcal			assurance program will be put	tinto	
	vaccine, dated 1/31	/24, indicated the resident			place:		
	consented to receive	ing the vaccination.			Pneumococcal QAPI develope	ed to	
					ensure all residents receive		
	The electronic med	ical record did not include any			vaccinations requested, this to	ool	
		istration of the pneumococcal			will be completed daily x4 wee	eks,	
	vaccination after the	e signed consent form on			monthly for 6 months, and		
	1/31/24.				quarterly thereafter by the		
					DNS/Designee.		
		y, on 10/22/24 at 10:11 a.m., the			The QAPI committee will revie		
		immunization should have			monthly and if 100% complian	ice	
	been provided soon	after the consent was signed,			is not achieved plan will be		
	but it had not been	ordered or given.			developed.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 10/23/2024			
		155243	B. W.	ING		10/23/	2024
	PROVIDER OR SUPPLIER			300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TF	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		rd for Resident 41 was reviewed					
		a.m. The diagnoses included,					
		d to, chronic obstructive					
	1 -	acquired absence of left leg ripheral vascular disease,					
	_	ity, current long-term use of					
		current long-term use of					
	opiate analgesic.	<i>6</i>					
		nt form for the pneumococcal					
		/23, indicated the resident did					
	not consent to receiving the vaccination.						
	A physician's order, dated 10/25/23, indicated						
		Valent Conjugate Vaccine 0.5					
		cted intramuscularly (IM) one					
	time for immunizat						
	A medication admi	nistration record (MAR), dated					
	_	/31/23, indicated 0.5 ml					
	_	valent conjugate vaccine was					
		n 10/25/23 at 1:54 p.m., to the					
	resident.						
	A medication admi-	nistration record (MAR), dated					
		/31/23, indicated to monitor the					
		fects from the pneumonia					
		for 3 Days starting 10/25/2023					
	at 2:00 p.m.						
		10/00/01 11/00					
	1	v, on 10/23/24 at 11:28 a.m., the					
		pneumococcal consent form icated the resident had					
		ation. She indicated she did					
		onsent for the vaccine					
	administration on 1						
	asiminonation on 1						
	4. The clinical reco	rd for Resident 84 was reviewed					
	on 10/21/24 at 9:56	a.m. The diagnoses included,					
		d to, end stage renal disease,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>	COMPLETED
155243 B. WING	10/23/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF LAFAYETTE STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROMOTERS IN AN OF CORPORATION	(X5)
PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (FACIL DEFICIENCY MUST BE RECEDED BY FILL DEFENY (FACIL DEFICIENCY ACTION SHOULD BE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATION	DATE
chronic pulmonary edema, acute and chronic	
respiratory failure with hypoxia, type 2 diabetes	
mellitus with diabetic polyneuropathy, metabolic	
encephalopathy, severe morbid obesity,	
peripheral vascular disease, anemia, paraplegia, dependence on renal dialysis, pleural effusion,	
and bradycardia.	
and oraclyculate.	
An informed consent form for the pneumococcal	
vaccine, dated April 2024, indicated the resident	
consented to receiving the vaccination.	
An information of four foodless and the superior of	
An informed consent form for the pneumococcal vaccine, dated 8/19/24, indicated the resident	
consented to receiving the vaccination.	
consented to receiving the vaccination.	
The electronic medical record did not include any	
record of the administration of the pneumococcal	
vaccination after the signed consent form in April	
or August 2024.	
During an interview, on 10/22/24 at 10:11 a.m., the	
DON indicated the immunization should have	
been provided soon after the consent was signed,	
but it had not been ordered or given after the	
April or August consents.	
A CONTRACTOR OF THE CONTRACTOR	
A current policy, titled "Infection Prevention &	
Control Program," dated 1/2/24 and received from the DON upon entrance, indicated	
"Documentation will reflect the education	
provided and details whether or not the resident	
received the immunizations"	
A current policy, titled "Pneumococcal	
Vaccination," dated 1/2/24 and received from the	
Clinical Support on 10/22/24 at 4:05 p.m., indicated	
"It is our policy to offer residents and staff	
immunization against pneumococcal disease in accordance with current CDC guidelines and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155243	B. WI	NG		10/23	/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	signed prior to the a	A consent form shall be administration of the vaccine vidual's medical record"						
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii COVID-19 Immun							
Eliag. 00	failed to ensure Cov when requested for immunizations. (Re Findings include: 1. The clinical record on 10/21/24 at 9:56 but were not limited depressive disorder B12 deficiency and generalized anxiety hypertension, and a An informed conservaccine, dated 1/13 consented to receive An informed conservaccine, dated 11/2 consented to receive The electronic median record of a Covid-1 consent form in Jan During an interview Director of Nursing	nt form for the Covid-19 0/23, indicated the resident ing the vaccination. ical record did not include any 9 vaccination after the signed uary or November 2023. v, on 10/22/24 at 10:11 a.m., the (DON) indicated the	F 08	87	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: 1. Audit performed facility wide all residents that are requesting receive the Covid 19 vaccines 10/22/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. All residents wanting the Could 19 vaccine have the potential affected. 2. All resident requesting/qual for Covid 19 vaccine will be reviewed for consents or declinations for the Covid 19 vaccine. 3. A COVID 19 clinic will be scheduled through the facility pharmacy to administer COVI vaccines for residents that have given consent and meet the qualifications on 11/14/2024 What measures will be put in place and what systemic chan	ents by the e for ng to s on he by the by the covid to be dify	11/14/2024	
		ld have been provided soon as signed, but it had not been			place and what systemic chan	-		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETE		ETED	
		155243	B. W	NG		10/23/	2024
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			NDY HILL DR		
MAJESTI	IC CARE OF LAFA	VETTE			ETTE, IN 47905		
WAGEOT	O CAIL OF LAFA			LAIAII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	ordered or given.				deficient practice does not rec	ur:	
					IPSD will conduct consents		
		ord for Resident 83 was reviewed			with all new admissions for Co		
		a.m. The diagnoses included,			19 vaccine within 72 hours aft		
		d to, hemiplegia and			admission and schedule vacci	ne if	
	-	ing cerebral infarction affecting			warranted.		
	right dominant side				2. IPSD will be in educated by	the	
		hagia, epilepsy not intractable			DNS/ADNS on the Covid 19		
	_	epticus, aphasia, and recurrent			vaccine with administration on		
	major depressive di	isorder.			11/9/2024.		
	A ' C 1	46 6 4 6 1110			3. IPSD will audit each admiss		
		nt form for the Covid-19			within 72 hours post admission		
vaccine, dated 12/18/23, indicated the resident				the Covid 19 vaccination. This			
	consented to receiving the vaccination.				audit will occur with each	- 4-	
	An informed compo	nt form for the Covid-19			admission x6 months. Finding	ร เช	
		2/23, indicated the resident			be submitted to the Executive		
		ing the vaccination.			Director. How the corrective actions will	ha	
	consented to receiv	ing the vaccination.			monitored to ensure the defici		
	The electronic med	ical record did not include any			practice will not recur what qui		
		9 vaccination after the signed			assurance program will be put	-	
	consent form on 12	_			place:	into	
	consent form on 12	110/23 01 12/22/23.			Covid 19 QAPI developed to		
	During an interviev	v, on 10/22/24 at 10:11 a.m., the			ensure all residents that reque	est	
	~	immunization should have			vaccine will receive the vaccin		
		a after the consent was signed,			this tool will be completed dail		
	but it had not been				weeks, monthly for 6 months,	-	
		-			quarterly thereafter by the		
	3. The clinical reco	rd for Resident 84 was reviewed			DNS/Designee.		
	on 10/21/24 at 9:56	a.m. The diagnoses included,			The QAPI committee will revie	•W	
	but were not limited	d to, end stage renal disease,			monthly and if 100% complian	ce	
	chronic pulmonary	edema, acute and chronic			is not achieved plan will be		
		with hypoxia, type 2 diabetes			developed.		
		tic polyneuropathy, metabolic					
		vere morbid obesity,					
		disease, anemia, paraplegia,					
	_	al dialysis, pleural effusion,					
	and bradycardia.						
	An informed conse	nt form for the Covid-19					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/23/2024			
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PROVIDERS PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		(X5) COMPLETION
TAG	vaccine, dated 8/19/	24, indicated the resident	TAG	DEFICIENCY)	DATE
		ical record did not include any 9 vaccination after the signed			
	DON indicated the been provided soon	y, on 10/22/24 at 10:11 a.m., the immunization should have after the consent was signed, ordered or given after the			
	Control Program," of the DON upon entra "Documentation v	will reflect the education s whether or not the resident			
	Management," date DON upon entrance Vaccination 1. Each Covid-19 vaccine will include docume	led "Covid-19 Prevention and d 1/2/24 and received from the e, indicated "Resident in resident will be offered the The resident's medical record entation that indicatesthe ovid-19 vaccine administered			
	This citation relates	to Complaint IN00441551.			
	3.1-18(b)(5)				
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/S	anitary/Comfortable Environ			
J	failed to ensure inco personal items were	on and interview, the facility ontinence products and stored appropriately, lighting use, and trash was not on	F 0921	F921 What corrective actions will be accomplished for those reside found to have been affected by	ents

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED 10/23/2024		
15524		155243	B. WING					
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	R			NDY HILL DR			
MAJESTIC CARE OF LAFAYETTE				LAFAYETTE, IN 47905				
1717 10 20 1	10 07 11 12 01 127 117 1			L/ (1 / (1	2112, 114 17 000			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX			P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	the ground for 5 of 70 rooms reviewed for environment (Rooms 112, 123, 134, 138, and 233). Findings include: 1. During an observation, on 10/16/24 at 11:07				deficient practice?			
					1. Incontinence products were	e		
				immediately removed from				
					in room 112 on 10/23/2024.			
				2. Light bulbs were im		ely		
					replaced in room 123 on			
	a.m., Room 112 had incontinence products, and an				10/23/2024.			
	opened package of briefs stored on the bed next				3. Paint on the floor in room 134			
	to the resident.				was removed immediately on			
	to the resident.				10/23/2024.			
	2. During an observation, on 10/16/24 at 10:29 a.m., Room 123 had a foul smell and the light				4. Clothes were hung up, clos	et		
					organized and items were			
	above the bed had 2 light bulbs not working.				immediately removed from the	е		
					floor in room 134 on 10/23/20	24.		
	3. During an observ	vation, on 10/16/24 at 10:49			5. Incontinence products were	9		
	a.m., Room 134 had	d paint on the floor, clothes not			immediately removed from the	е		
	hung up, the closet was a mess, and items were on				ground, toothbrush immediate	ely		
	the floor.				removed from the back of the	toilet		
					in room 138 on 10/23/2024.			
	4. During an observation, on 10/16/24 at 10:46				6. Trash on the floor was			
	a.m., Room 138 ha	d briefs stored on the ground in			immediately removed and			
	the bathroom, a toothbrush and a hairbrush with			disposed, breakfast food ite		S		
	other supplies were stored in a wire basket on the back of the toilet.				were removed, filled urinal wa	ıs		
					emptied & replaced in an			
					appropriate location in room 2	233		
	5. During an observ	vation, on 10/16/24 at 11:17			on 10/23/2024.			
	a.m., Room 233 had trash on the floor, food from breakfast, and a filled urinal on the bedside table.An environmental tour and interview were completed with the Maintenance Supervisor, the				How other residents having th	ne		
					potential to be affected by the	!		
					same deficient practice will be	9		
					identified and what corrective			
					action(s) will be taken.			
	ED (Executive Director), and Housekeeping on			1. All residents have the potential		ntial		
	10/20/24 at 1:42 p.m. They indicated they needed			to affected by the alleged deficient				
	to replace some of the light bulbs, redo the				practice.			
	flooring where the paint was on the ground, and				2. All resident rooms were			
	keep up with the trash on the ground in the				assessed for cleanliness, clutter			
	rooms. Incontinenc	e products should not be			and inappropriate placement	of		
stored on the ground, and they could get a 3-level				supplies, personal items and				
shelf to store some of the incontinence products				urinals on 10/23/2024.				

on.

What measures will be put into

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OND TO COMPANY OF THE SERVICE OF THE											
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED						
155243		155243	B. WING		10/23/2024						
NAME OF P	ROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD							
				300 WINDY HILL DR							
MAJEST	IC CARE OF LAFA	YETTE	LAFAYETTE, IN 47905								
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)					
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	SHOULD BE COMPLETIO						
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ILE	DATE					
	A facility policy, titled "RESIDENT RIGHTS,"			place and what systemic chan	iges						
				will be made to ensure that the							
	dated 1/2/24 and received from the Clinical			deficient practice does not rec	ur.						
	Support on 10/16/24 at 3:03 p.m., indicated "The			1. All staff were educated o							
	resident has a right to a safe, clean, comfortable,			infection control, proper handling							
	and homelike envir	onment, including but not		of soiled linens on 11/09/2024 by							
	limited to receiving	treatment and support for		IP/DNS/Regional IP.							
	daily living safely"			How the corrective action(s) will be							
				monitored to ensure the defici	ent						
	This citation relates	to Complaint IN00439138.		practice will not recur.							
	·			Environmental QAPI developed to							
	3.1-19(f)(5)			ensure all personal items are							
				stored correctly, this tools will be							
				complete daily x 4 weeks,							
				monthly for 6 months and							
				quarterly there after by the DN	IS or						
				designee.							
				The QAPI committee will revie	ew						
				monthly and if 100% complian	ice						
				is not achieved an action plan							
				be developed.							

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