STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 00 B. WING	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00430580, IN00434180, IN00435618, IN00436115, IN00436796, IN00439138, IN00439867 IN00441551, IN00443626 and IN00444172. Complaint IN00430580 - Federal/state deficiencies related to the allegations are cited at F550. Complaint IN00434180 - No deficiencies related to the allegations are cited. Complaint IN00435618 - Federal/state deficiencies related to the allegations are cited at F804. Complaint IN00436115- No deficiencies related to the allegation are cited. Complaint IN00436796 - Federal/state deficiencies related to the allegations are cited at F804. Complaint IN00439138 - Federal/state deficiencies related to the allegations are cited at F804 and F921. Complaint IN00439867 - No deficiencies related to the allegation are cited. Complaint IN00441551 - Federal/state deficiencies related to the allegations are cited at F887. Complaint IN00443626 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00444172 - No deficiencies related to the allegations are cited.	F 0000	Please accept this response as our credible allegation of compliance for Majestic Care of Lafayette. We respectfully request a desk review for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian	Lessley	11/13/2024

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	Survey dates: October 16, 17, 18, 21, 22 and 23, 2024 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 7 Medicaid: 77 Other: 8 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 28, 2024.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to ensure care given to a resident was not completed by a particular staff member according to the resident's preference for 1 of 1 resident reviewed for resident rights. (Resident D) Finding includes: During an interview, on 10/16/24 at 10:14 a.m., Resident D indicated he did not want RN 7 to take care of him and he had informed management staff. RN 7 was still taking care of him.	F 0550	br1. RN 7 immediately removed 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 affected by this deficient practice.brWhat measures will be put in place and what systemic changes will be made to ensurethat the deficient practice does not recur:brAll staff will be educated upon hire,	11/09/2024

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	During an interview, on 10/22/24 at 10:12 a.m., the Director of Nursing (DON) indicated she was aware RN 7 was not supposed to be taking care of Resident D. She was assigned to the hall often but was not to take care of Resident D. The clinical record for Resident D was reviewed on 10/17/24 at 3:29 p.m. The diagnoses included, but were not limited to, schizoaffective disorder, bipolar type, anxiety disorder and problem related to unspecified psychosocial circumstances. A Medication Administration Record (MAR) indicated RN 7 administered Resident D's medications on 9/1, 9/3, 9/4, 9/6, 9/7, 9/8, 9/9, 9/11, 9/20, 9/21, 9/22, 9/23, 10/5, 10/6, 10/12, and 10/16/24. A vitals tab indicated RN 7 obtained vital signs for Resident D on 9/1, 9/3, 9/4, 9/6, 9/8, 9/9, 9/11, 9/20, 9/21, 9/22, 9/23, 10/5, 10/6, 10/12, and 10/16/24. During an interview, on 10/23/24 at 10:00 a.m., LPN 8 indicated the resident had been expressing he did not want RN 7 to take care of him ever since she started working here. During an interview, on 10/23/24 at 11:25 a.m., the DON indicated it did appear as if RN 7 had been taking care of the resident. A facility policy, titled "RESIDENT RIGHTS," dated 1/2/24 and received from the Clinical Support on 10/16/24 at 3:03 p.m., indicated "...The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has the right to choose activities, schedules (including sleeping		quarterly, and as needed.brHow the corrective actions will be monitored to ensure the deficient practice will notrecur:brThe QAPI committee will review monthly and if 100% compliance is not achieved an actionplan will be developed. F550 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. RN 7 immediately removed from resident D care on 10/22/2024. 2. RN 7 inserviced on 10/22/2024 on Resident Rights by DNS. 3. Resident D's careplan was updated on preferences on 10/23/2024 by SSD. 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 have the potential to be affected by this deficient practice. 2. All residents that reside in the facility were reviewed for preferences by the SSD on 11/7/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. All staff were educated on Resident Rights on 11/9/2024 by	

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	and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part...." This citation relates to Complaint IN00430580. 3.1-3(t)		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 be monitored to ensure the deficient practice will not recur: Resident Preference/Resident Rights QAPI tool developed to ensure resident rights are being followed. 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% compliance is not achieved an action plan will be developed.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to ensure staff notified the Social Service Director and the resident's physician immediately after the resident expressed suicidal thoughts for 1 of 1 resident reviewed for notification. (Resident 81) Finding includes: During an interview, on 10/21/24 at 10:06 a.m., Resident 81 indicated she told a nurse, on 10/19/24, she felt like killing herself and wanted to get help. She had increased feelings of depression and anxiety and was very upset nothing was	F 0580	F580 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident 81 was immediately seen by SSA on 10/21/2024. 2. SSA immediately reached out to psych services and completed a telehealth visit on 10/21/2024. 3. Medical director came to building on 10/21/2024 and completed an evaluation for resident 81.	11/09/2024

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	done. The clinical record for Resident 81 was reviewed on 10/12/22 at 11:25 a.m. The diagnoses included, but were not limited to, major depressive disorder and general anxiety. A physician's order, dated 5/18/24, indicated to give 60 milligrams (mg) of duloxetine delayed release for depression daily. A physician's order, dated 10/2/24, indicated to give 10 mg of buspirone for anxiety three times a day. A care plan, dated 7/23/24, indicated the resident was on a psychotropic medication. Interventions included, but were not limited to, monitor for side effects of antidepressant medication and suicidal thoughts. During an interview, on 10/21/24 at 11:18 a.m., the Social Service Assistant (SSA) indicated the resident came to her and indicated she wanted help. During an interview, on 10/21/24 at 11:21 a.m., the SSA indicated she was notified, at 11:00 a.m., by the resident she had suicidal thoughts over the weekend, and she had told her nurse. The procedure when a resident voiced suicidal thoughts was to put them on 15-minute checks and to immediately call the Director of Nursing (DON) and SSA. The DON and SSA were not notified until 10/21/24 at 11:00 a.m. During an interview, on 10/21/24 at 11:28 a.m., the Executive Director asked the SSD if the resident told staff about the incident and the SSA indicated the resident told a nurse.		4. Psych services discontinued 15 minute checks on 10/21/2024 for resident 81. 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 with suicidal ideation/thoughts have the potential to be affected by this deficient practice. 2. All residents that reside in the facility were assessed for suicidal ideation based on diagnosis and PHQ9 on 10/21/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. All staff were educated on 10/22/2024 by DNS/Designee to immediately report any suicidal ideation to charge nurse, DNS, SSD, resident's representative, and physician. All staff will be educated upon hire, quarterly, and as needed. 2. All nursing staff were educated on 10/22/2024 by DNS/Designee to document the resident's mood/behaviors, as well as the actions taken in the medical record. All staff will be educated upon hire, quarterly, and as needed. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into	

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	During an interview, on 10/21/24 at 1:39 p.m., the DON indicated she was unaware the resident had voiced suicidal thoughts over the weekend. The resident had increased anxiety. The procedure when a resident voiced suicidal thoughts was to call the DON and SSD first thing so they could start a plan. She should have been notified and was not. There was no documentation to indicate the DON, SSA or physician were notified of Resident 81's suicidal thoughts. A current policy, titled "Suicidal Thoughts & Ideations," dated 1/2/24 and received from the Clinical Support Nurse on 10/21/24 at 10:16 a.m., indicated "...All staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker. Immediately notify the resident's physician if the resident presents with suicidal ideation, even if he or she isn't specific about a plan or intent...Objectively document the resident's mood and behaviors, as well as all actions taken, in the medical records...." A current policy, titled "Change in Condition/Physician Notification," dated 1/2/24 and received from the Director of Nursing on 10/16/24 at 3:30 p.m., indicated "...The nurse will notify the physician/NP/PA and the resident/resident's representative when: A significant change in the resident's physical, mental, or psychosocial status...." 3.1-5(a)(2)		place: Behavior Management QAPI developed to insure policy is being followed correctly, this 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% compliance is not achieved an action plan will be developed.	
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and			

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Bldg. 00	Suctioning Based on observation, interview and record review, the facility failed to administer the correct amount of oxygen as ordered by the physician for 1 of 1 resident reviewed for respiratory care. (Resident 5) Finding includes: During an observation, on 10/16/24 at 11:15 a.m., Resident 5's oxygen concentrator (a device used to provide supplemental oxygen therapy) was set on 2 liters per minute (L). During an observation, on 10/17/24 at 9:57 a.m., Resident 5's oxygen concentrator was set on 2.5L. During an observation, on 10/18/24 at 11:31 a.m., Resident 5's oxygen concentrator was set on 2L. The clinical record for Resident 5 was reviewed on 10/17/24 at 3:30 p.m. The diagnoses included, but were not limited to, end stage renal disease, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, chronic kidney disease, interstitial pulmonary disease, chronic pulmonary edema, personal history of malignant neoplasm of other sites of lip, oral cavity and pharynx, gastrostomy status, and dependence on renal dialysis. A care plan, dated 7/12/23, indicated the resident was on oxygen therapy. Interventions included, but were not limited to, observe for signs of respiratory distress and administer oxygen per order. A physician's order, dated 6/21/24, indicated the resident was to receive 1L of oxygen continuously.	F 0695	F695 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident 5 was immediately evaluated by nursing on 10/18/2024 and oxygen saturation corrected. 2. Resident 5 was monitored beginning on 10/18/24 x3 days for respiratory distress. 3. Nursing notified NP on 10/18/2024 of oxygen saturation and received no new orders for resident 5. 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 that have an oxygen order have the potential to be affected by this deficient practice. 2. All residents in the facility with oxygen orders were assessed for correct oxygen settings on 10/18/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. All staff were educated on following physician's orders for oxygen settings on 11/9/2024 by the DNS/Designee. All staff will be educated upon hire, quarterly, and as needed.	11/09/2024

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	During an interview, on 10/18/24 at 11:39 a.m., QMA 4 indicated the resident's oxygen concentrator was on 2L. She was unsure of the resident's ordered liter flow. During an interview, on 10/18/24 at 11:43 a.m., LPN 3 indicated the resident's order was for 1L. During an interview, on 10/23/24 at 11:23 a.m., the Director of Nursing (DON) indicated Resident 5's oxygen liter flow was previously at the wrong setting and staff should have followed the physician's orders. A current policy, titled "Oxygen Administration," dated 12/12/23 and received from the Clinical 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)		How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: Respiratory QAPI tool developed to monitor oxygen settings compared with PCC orders, along with supplies and storage, this be completed daily x4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure staff accurately documented on the narcotic count sheets, documented medication administration in the Medication Administration Record, and properly documented the disposal of medication for 1 of 2 residents reviewed for pain management. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/16/24 at 11:46 a.m. The diagnosis included, but	F 0755	F755 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. DNS completed audit for resident E's narcotic count sheet and electronic medical record on 10/22/2024 . 2. LPN 9 was inserviced on 10/22/2024 by the DNS on narcotic disposal policy.	11/09/2024

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	were not limited to, chronic pain syndrome and non-pressure chronic ulcer of foot. a. The following entries were documented in the month of August on a narcotic medication count sheet for Oxycodone (a narcotic medication to treat pain) 5 milligrams: 1. An entry, dated 8/3/24 at 5:00 a.m., indicated one Oxycodone was administered. This administration was not documented in the Medication Administration Record (MAR). 2. An entry, dated 8/3/24 at 6:20 p.m., indicated one Oxycodone was administered. This administration was not documented in the MAR. 3. An entry, dated 8/3/24 at 3:15 p.m., indicated one Oxycodone was administered. This administration was not documented in the MAR, had a single line strike through the entry, and was not initialed by the nurse. The documentation did not indicate 2 nurses' signatures were documented to show the medication was wasted and the medication was not documented in the MAR indicating the medication had been administered. On 8/3/24, two entries were out of chronological order. An entry was made for at 6:20 p.m., with a subsequent entry made at 3:15 p.m. During an interview, on 10/22/24 at 11:21 p.m., the Assistant Director of Nursing (ADON) indicated if a narcotic medication needed to be wasted, two nurses would sign the narcotic count sheet, and		3. Nurse manager was immediately educated on 10/22/2024 by the DNS that the waste/disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. 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 with orders for a controlled medication have the potential to be affected by this deficient practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. All nursing staff were educated on correctly documenting narcotic medication on the count sheet and in the electronic medical record on 11/9/2024 by the DNS/Designee. All nursing staff will be educated upon hire, quarterly, and as needed. 2. All nursing staff were educated on 11/9/2024 by the DNS/Designee that two nurse's signatures are required to waste a narcotic medication. All nursing staff will be educated upon hire, quarterly, and as needed. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into	

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	the medication would be destroyed. 4. An entry, dated 8/4/24 at 7:14 p.m., indicated one Oxycodone was administered. This administration was not documented in the MAR. 5. A physician order, with a start date of 8/21/24 and end date of 8/28/24, indicated Oxycodone HCI Oral Tablet 10 mg, give 1 tablet by mouth every 6 hours as needed for chronic pain for 7 days, may use two 5 milligram tabs until 10 milligrams arrived. The MAR indicated, on 8/21/24, Oxycodone 10 milligrams was administered. The documentation on the narcotic count sheet indicated, on 8/21/24 at 11:52 a.m., one Oxycodone 5 milligram was administered, indicating an incorrect documentation of the amount given. During an interview, on 10/22/24 at 1:15 p.m., the ADON indicated the nurse incorrectly documented the amount given. b. The following entries were documented in the month of September on the narcotic medication count sheet for Oxycodone 5 milligrams: 1. An entry, dated 9/14/24 at 5:20 p.m., indicated one Oxycodone was administered. This administration was not documented in the MAR. 2. An entry, dated 9/18/24 at 10:19 a.m., indicated one Oxycodone was administered and the remaining quantity was one.		place: Pharmacy QAPI tool develop to ensure all PRN narcotic will have proper documentation in EMAR, this will be completed daily x4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	

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	3. An entry, dated 9/18/24 at 5:00 p.m., indicated one Oxycodone was administered and the remaining quantity was one. The remaining quantity documented on this entry was incorrect. 4. An entry, dated 9/18/24 at 5:00 p.m., indicated one Oxycodone was administered and the remaining quantity was zero. This entry did not have a nurse signature. During an interview, on 10/22/24 at 3:00 p.m., the Director of Nursing (DON) indicated she was aware the nurses were signing out the medication on the medication count sheet but not documenting the administration in the MAR. c. Review of a narcotic count sheet for a discontinued medication order of Oxycodone 10 milligrams, indicated 28 doses remained and were destroyed on 5/30/24. The documentation indicated LPN 9 signed the disposition of the remaining 28 doses on the narcotic count sheet and failed to obtain a witness signature. During an interview, on 10/22/24 at 11:21 p.m., the ADON indicated when a narcotic medication was destroyed, the unit manager and a nurse would destroy the remaining quantity, and both would sign the disposition sheet. During an interview, on 10/22/24 at 1:14 p.m., the ADON reviewed the disposition of remaining doses on the narcotic count sheet, dated 5/30/24, and indicated she was not sure why the disposition did not have a witness signature. She			

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	indicated, as the unit manager, she should have witnessed the destruction of the discontinued medication and signed as the witness. A current policy, titled "Medication Administration," dated 1/2/2024 and received by the DON on 10/22/24 at 3:00 p.m., indicated "...Sign MAR after administered...." A current policy, titled "Documentation of Mediation Administration," last revised 4/2007 and received by the DON on 10/22/24 at 3:00 p.m., indicated "...A Nurse of Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR)...Administration of medication must be documented immediately after (never before) it is given...." A current policy, titled "Controlled Substances," last revised 4/2019 and received by the DON on 10/22/24 at 3:00 p.m., indicated "...The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medication...Upon disposition...Medication that are opened and subsequently not given (refused or partly administered) are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet...." This citation relates to Complaint IN00443626. 3.1-25(e)(2) 3.1-25(o) 3.1-25(s)(8)			

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F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, interview and record review, the facility failed to ensure a resident was assisted and received dental services for 1 of 1 resident reviewed for dental services. (Resident 8) Finding includes: During an observation, on 10/16/24 at 11:27 a.m., Resident 8 had missing teeth. During an interview, on 10/16/24 at 11:27 a.m., Resident 8 indicated she wanted new dentures. She previously lost a large amount of weight, and her old dentures no longer fit. She indicated she would like to get new ones, but staff had not helped her to find a provider in her insurance network when she asked for assistance. The clinical record for Resident 8 was reviewed on 10/16/24 at 3:02 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, peripheral vascular disease, chronic diastolic heart failure, post-traumatic stress disorder, hyperlipidemia, and age-related physical debility. A physician's order, dated 9/19/22, indicated Resident 8 may be seen by a podiatrist, dentist, optometrist, audiologist, psychiatrist, and psychologist. A care plan, dated 9/11/22, indicated Resident 8 was at risk for oral and dental health problems due to being edentulous (having missing teeth). Interventions included, but were not limited to, coordinate arrangements for dental care, transportation as needed and as ordered.	F 0791	F791 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. SSA immediately made an appointment, on 10/21/2024, with Advantage Dentures for Resident 8. 2. Resident 8 seen in office for evaluation and treatment on 10/30/2024. 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 with dental needs have the potential to be affected by this deficient practice. 2. Audit performed on 10/21/2024 for all current residents that have been seen by Aria dental in the last 3 months for potential deficient practice. 3. Audit performed on 10/21/2024 for all residents in the facility for all desired denture services. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. SSD/SSA were educated on 11/9/2024 by DNS/Designee that after each dental evaluation in the facility, the SSD/SSA is to review all final reports.	11/09/2024

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	A care plan, revised on 9/30/24, indicated Resident 8 needed assistance with activities of daily living. Interventions included, but were not limited to, staff to assist and encourage oral care twice daily. A dental note, dated 7/31/23, indicated Resident 8 had no teeth or dentures present. Her oral tissue was within normal limits and the resident wanted dentures made. A dental note, dated 3/12/24, indicated Resident 8 wanted new upper and lower complete dentures. A dental note, dated 8/7/24, indicated Resident 8 was fully edentulous with no removable appliances present. The resident stated she would like dentures made. Her oral tissue was generalized healthy with no significant findings on visual exam. 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 routine...and emergency dental care...Oral care and		2. All staff were educated on 11/9/2024 on notifying social services if resident is needing/requesting dental services. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: Dental QAPI tool developed to ensure all dental needs are met, this will be completed daily x4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	

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	denture care shall be provided in accordance with identified needs and as specified in the plan of care...Referrals to...dental provider shall be made as appropriate...The 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 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation and interview, the facility failed to ensure food was served at a safe and appetizing temperature for 1 of 1 room tray tested for temperatures. (100 hall) Findings include: During an interview, on 10/16/24 at 10:54 a.m., Resident E indicated the food was usually cold, especially for room trays. During an interview, on 10/16/24 at 2:53 p.m., Resident 48 indicated the food was cold a lot. During a resident council meeting, on 10/18/24 at 2:35 p.m., the resident council indicated the food was cold, even when eating in the dining room. During an observation and interview, on 10/16/24 at 12:40 p.m., a lunch tray was chosen to get food temperatures. The ravioli temped at 116 degrees. The dietary manager indicated hot foods should be served at least 120 degrees or above. A facility policy, titled "Food: Quality and Palatability," last revised on 2/2023 and received	F 0804	F804 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident E was interviewed for food preferences by the dietary manager on 10/16/2024. 2. Resident 48 was interviewed for food preferences by the dietary manager on 10/16/2024. 3. The ravioli temped at 116 degrees F was immediately exchanged for another tray temped at over 120 degrees F. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected by the alleged deficient practice. 2. For all residents with an unsatisfactory temperature, the food will be replaced or reheated	11/09/2024

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	from the Director of Nursing on 10/16/24 at 3:30 p.m., indicated "...Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature...Proper (safe and appetizing) temperature. Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns...." This citation relates to Complaints IN00435618, IN00436796, and IN00439138. 3.1-21(a)(2)		at their request by direct care staff. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The CDM and all dietary staff were re-educated on facility policy and procedure for food temperatures. 1. Food temperatures will be monitored and recorded daily in the kitchen by the CDM or designee as trays are prepared for delivery to the floor. 2. Food temps will be checked at random on tray carts as delivered to the floor daily by the CDM or designee. 3. The efforts will be reviewed with Resident Council monthly to assess satisfaction with food temps. 4. Daily rounds will be made by the IDT team to assess resident satisfaction with food temperature. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. A dietary QAPI tool developed to ensure food temperature are within range, this will be completed daily x 4 weeks and monthly for 6 months and quarterly thereafter by the ED or designee. The QAPI Committee will review monthly and if compliance is not achieved an action plan will be developed.	

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to document mood and behaviors in the Electric Health Records (EHR) for 1 of 1 resident with suicidal thoughts. (Residents 81) Finding includes: During an interview, on 10/21/24 at 10:06 a.m., Resident 81 indicated she told a nurse, on 10/19/24, she felt like killing herself and wanted to get help. The resident was very upset. The clinical record for Resident 81 was reviewed on 10/12/24 at 11:25 a.m. The diagnoses included, but were not limited to, major depressive disorder and general anxiety. A physician's order, dated 5/18/24, indicated to give 60 milligrams (mg) of duloxetine delayed release for depression daily. A physician's order, dated 10/2/24, indicated to give 10 mg of buspirone for anxiety three times a day. There was nothing documented in the EHR about the thoughts and feeling Resident 81 was having. During an interview, on 10/21/24 at 11:21 a.m., the Director of Nursing (DON) indicated the staff should document the resident's mood and behavior in the medical records and nothing was charted. A current policy, titled "Suicidal Thoughts & Ideations," dated 1/2/24 and received from the Clinical Support Nurse on 10/21/24 at 10:16 a.m.,	F 0842	F842 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Unit manager, nurse, and social services immediately educated on documenting resident's behaviors/moods in the medical record on 10/21/2024 by the DNS. 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 have the potential to be affected by this deficient practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. All nursing staff were educated on 10/22/2024 by DNS/Designee to document resident's mood/behaviors, as well as the actions taken in the medical record for a resident with suicidal ideation. All staff will be educated upon hire, quarterly, and as needed. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: Behavior Management QAPI	11/09/2024

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	indicated "...All staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker. Immediately notify the resident's physician if the resident presents with suicidal ideation, even if he or she isn't specific about a plan or intent...Objectively document the resident's mood and behaviors, as well as all actions taken, in the medical records...." 3.1-50(1)		developed to ensure SI policy and procedures are being followed, this 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% compliance is not achieved an action plan will be developed.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure staff transported soiled linen down the hall correctly and staff wore PPE (personal protective equipment) into an isolation room for 3 of 3 randomly observed staff. (CNA 12, 13 and 14) Findings include 1. During an observation, on 10/18/24 at 11:45 a.m., Certified Nursing Assistant (CNA) 12 was observed dragging a large clear trash bag of dirty linen down the 100 hall and placed the bag into the soiled utility room. During an interview, on 10/18/24 at 11:48 a.m., CNA 12 indicated she should not drag dirty linen down the hall. During an interview, on 10/18/24 at 11:49 a.m., the Director of Nursing (DON) indicated the CNA was not supposed to drag dirty linen down the hall. 2. During an observation, on 10/18/24 at 11:52 a.m., Resident G was in Enhanced Barrier	F 0880	F880 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. CNA 12 was educated by the DNS on 10/18/2024, for handling soiled linens. 2. CNA 13 and CNA 14 immediately educated on 10/18/2024 on how and when to wear PPE in an isolation room, by the DNS. 3. A chart review and resident observation of Resident G completed by DNS/designee revealed no negative outcomes related to the cited deficient practice on 10/18/2024. 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 that are currently	11/09/2024

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	Precautions (EBP). CNA 13 and CNA 14 was in the resident's room transferring the resident from her wheelchair to the bed. The CNAs were not wearing PPE when touching the resident, wheelchair, and bed. Licensed Practical Nurse (LPN) 6 entered the room wearing gloves and saw the CNAs without PPE. LPN 6 handed a gown enclosed in a clear bag to CNA 13 and instructed her to put it on. LPN 6 told CNA 14 she also needed to put on a gown and gloves. CNA 14 put on her gown and did not tie the back of the gown. 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 resident's bedside without gloves. CNA 14 started to place a pillow under the resident's head and reposition the resident without wearing gloves. The clinical record for Resident G was reviewed, on 10/18/24 at 10:46 a.m. The diagnoses included, but were not limited to, end stage renal, major depressive disorder, and hypertension. A physician's order, dated 10/18/24, indicated EBP when engaging in high contact resident care activities. During an interview, on 10/18/24 at 12:03 a.m., CNA 14 indicated she was not aware gloves were needed when putting a pillow under the resident's head. During an interview, on 10/18/24 at 12:07 a.m., LPN 6 indicated CNA 14 needed to put gloves on before touching the resident and gowns need to be tied when providing care. A current policy, titled "Hand Hygiene," dated 1/2/24 and provided by the Director of Nursing on		in enhanced barrier precautions have the potential to be affected by this deficient practice. 2. All residents have the potential to be affected by the deficient practice of handling soiled linens. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. All staff to be educated on 11/9/2024 for PPE and enhanced barrier precautions on 11/9/24, by the DNS/Designee. 2. All staff education completed for handling soiled linens on 11/9/24 by the DNS/designee. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: PPE QAPI developed to monitor donning and doffing of PPE, this will be completed daily x 4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. Soiled linens QAPI developed to ensure lines are being handled following policy and procedure, this will be completed daily x4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	

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	10/23/22 at 2:04 p.m., indicated "...All staff will perform proper hand hygiene procedures to prevent the spread of infection...." A current policy, titled "Infection Prevention & Control Program," dated 1/2/24 and provided at entrance on 10/16/24, indicated "...Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE...Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection...All staff shall demonstrate competence in relevant infection control practices...." 3.1-18(b) 3.1-18(l)			
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on interview and record review, the facility failed to ensure pneumococcal vaccines were administered according to the signed consent form for 4 of 7 residents reviewed for immunizations. (Resident I, 9, 41 and 84) Findings include: 1. The clinical record for Resident I was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, sepsis, acute cystitis with hematuria, cellulitis, type 2 diabetes mellitus with diabetic chronic kidney disease, acute kidney failure, chronic kidney disease stage 3, paroxysmal atrial fibrillation, anemia, long term current use of insulin, and essential primary hypertension.	F 0883	F883 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Audit performed facility wide for all residents that are requesting to 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 potential to be affected.	11/09/2024

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	An informed consent form for the pneumococcal vaccine, dated 8/19/24, indicated the resident 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 on 8/19/24. During an interview, on 10/22/24 at 10:11 a.m., the Director of Nursing (DON) indicated the immunization should have been provided soon after the consent was signed, but it had not been ordered or given. 2. The clinical record for Resident 9 was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, chronic bronchitis, asthma, chronic kidney disease stage 3, other forms of acute ischemic heart disease, chronic diastolic congestive heart failure, anemia, unspecified right bundle-branch block (disruption of the heart's electrical signal to the right side of the heart), essential primary hypertension, and obesity. An informed consent form for the pneumococcal vaccine, dated 1/31/24, indicated the resident 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 on 1/31/24. 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.		2. All resident requesting/qualify for pneumococcal vaccine will receive them by 11/9/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. IPSD will conduct consents with all new admissions for pneumococcal vaccine within 72 hours after admission and schedule vaccine if warranted. 2. IPSD will be in educated by the DNS/ADNS on the pneumococcal vaccine with administration on 11/9/2024. 3. IPSD will audit each admission within 72 hours post admission for the pneumococcal vaccination. This audit will occur with each admission x6 months. Findings to be submitted to the Executive Director. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: Pneumococcal QAPI developed to ensure all residents receive vaccinations requested, this tool will be completed daily x4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved plan will be developed.	

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	3. The clinical record for Resident 41 was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acquired absence of left leg below the knee, peripheral vascular disease, severe morbid obesity, current long-term use of anticoagulants, and current long-term use of opiate analgesic. An informed consent form for the pneumococcal vaccine, dated 4/19/23, indicated the resident did not consent to receiving the vaccination. A physician's order, dated 10/25/23, indicated Pneumococcal 20-Valent Conjugate Vaccine 0.5 milliliters (ml) injected intramuscularly (IM) one time for immunization. A medication administration record (MAR), dated 10/1/23 through 10/31/23, indicated 0.5 ml pneumococcal 20-valent conjugate vaccine was administered IM, on 10/25/23 at 1:54 p.m., to the resident. A medication administration record (MAR), dated 10/1/23 through 10/31/23, indicated to monitor the resident for side effects from the pneumonia vaccine every shift for 3 Days starting 10/25/2023 at 2:00 p.m. During an interview, on 10/23/24 at 11:28 a.m., the DON indicated the pneumococcal consent form for Resident 41 indicated the resident had declined the vaccination. She indicated she did not find a signed consent for the vaccine administration on 10/25/23. 4. The clinical record for Resident 84 was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, end stage renal disease,			

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(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
	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. An informed consent form for the pneumococcal vaccine, dated April 2024, indicated the resident consented to receiving the vaccination. An informed consent form for the pneumococcal vaccine, dated 8/19/24, indicated the resident 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 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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	155243	A. BUILDING 00 B. WING	10/23/2024

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	recommendations...A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record...." 3.1-18(b)(5)			
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on interview and record review, the facility failed to ensure Covid-19 vaccines were provided when requested for 3 of 7 residents reviewed for immunizations. (Resident 65, 83 and 84) Findings include: 1. The clinical record for Resident 65 was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, recurrent moderate major depressive disorder, vitamin D deficiency, vitamin B12 deficiency anemia, prolonged grief disorder, generalized anxiety disorder, essential primary hypertension, and age-related physical debility. An informed consent form for the Covid-19 vaccine, dated 1/13/23, indicated the resident consented to receiving the vaccination. An informed consent form for the Covid-19 vaccine, dated 11/20/23, indicated the resident consented to receiving the vaccination. The electronic medical record did not include any record of a Covid-19 vaccination after the signed consent form in January or November 2023. During an interview, on 10/22/24 at 10:11 a.m., the Director of Nursing (DON) indicated the immunization should have been provided soon after the consent was signed, but it had not been	F 0887	F887 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Audit performed facility wide for all residents that are requesting to receive the Covid 19 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 Covid 19 vaccine have the potential to be affected. 2. All resident requesting/qualify 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 COVID 19 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 changes will be made to ensure that the	11/14/2024

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	ordered or given. 2. The clinical record for Resident 83 was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, essential primary hypertension, dysphagia, epilepsy not intractable without status epilepticus, aphasia, and recurrent major depressive disorder. An informed consent form for the Covid-19 vaccine, dated 12/18/23, indicated the resident consented to receiving the vaccination. An informed consent form for the Covid-19 vaccine, dated 12/22/23, indicated the resident consented to receiving the vaccination. The electronic medical record did not include any record of a Covid-19 vaccination after the signed consent form on 12/18/23 or 12/22/23. 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. 3. The clinical record for Resident 84 was reviewed on 10/21/24 at 9:56 a.m. The diagnoses included, but were not limited to, end stage renal disease, 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. An informed consent form for the Covid-19		deficient practice does not recur: 1. IPSD will conduct consents with all new admissions for Covid 19 vaccine within 72 hours after admission and schedule vaccine if warranted. 2. IPSD will be in educated by the DNS/ADNS on the Covid 19 vaccine with administration on 11/9/2024. 3. IPSD will audit each admission within 72 hours post admission for the Covid 19 vaccination. This audit will occur with each admission x6 months. Findings to be submitted to the Executive Director. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: Covid 19 QAPI developed to ensure all residents that request vaccine will receive the vaccine, this tool will be completed daily x4 weeks, monthly for 6 months, and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved plan will be developed.	

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	vaccine, dated 8/19/24, indicated the resident consented to receiving the vaccination. The electronic medical record did not include any record of a Covid-19 vaccination after the signed consent form on 8/19/24. 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 8/19/24 consent. 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 "Covid-19 Prevention and Management," dated 1/2/24 and received from the DON upon entrance, indicated "...Resident Vaccination 1. Each resident will be offered the Covid-19 vaccine...The resident's medical record will include documentation that indicates...the date each dose of Covid-19 vaccine administered to the resident...." This citation relates to Complaint IN00441551. 3.1-18(b)(5)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure incontinence products and personal items were stored appropriately, light bulbs were in working use, and trash was not on	F 0921	F921 What corrective actions will be accomplished for those residents found to have been affected by the	11/09/2024

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	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 a.m., Room 112 had incontinence products, and an opened package of briefs stored on the bed next to the resident. 2. During an observation, on 10/16/24 at 10:29 a.m., Room 123 had a foul smell and the light above the bed had 2 light bulbs not working. 3. During an observation, on 10/16/24 at 10:49 a.m., Room 134 had paint on the floor, clothes not hung up, the closet was a mess, and items were on the floor. 4. During an observation, on 10/16/24 at 10:46 a.m., Room 138 had briefs stored on the ground in the bathroom, a toothbrush and a hairbrush with other supplies were stored in a wire basket on the back of the toilet. 5. During an observation, on 10/16/24 at 11:17 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 ED (Executive Director), and Housekeeping on 10/20/24 at 1:42 p.m. They indicated they needed to replace some of the light bulbs, redo the flooring where the paint was on the ground, and keep up with the trash on the ground in the rooms. Incontinence products should not be stored on the ground, and they could get a 3-level shelf to store some of the incontinence products on.		deficient practice? 1. Incontinence products were immediately removed from the bed in room 112 on 10/23/2024. 2. Light bulbs were immediately replaced in room 123 on 10/23/2024. 3. Paint on the floor in room 134 was removed immediately on 10/23/2024. 4. Clothes were hung up, closet organized and items were immediately removed from the floor in room 134 on 10/23/2024. 5. Incontinence products were immediately removed from the ground, toothbrush immediately removed from the back of the toilet in room 138 on 10/23/2024. 6. Trash on the floor was immediately removed and disposed, breakfast food items were removed, filled urinal was emptied & replaced in an appropriate location in room 233 on 10/23/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to affected by the alleged deficient practice. 2. All resident rooms were assessed for cleanliness, clutter and inappropriate placement of supplies, personal items and urinals on 10/23/2024. What measures will be put into	

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	A facility policy, titled "RESIDENT RIGHTS," dated 1/2/24 and received from the Clinical Support on 10/16/24 at 3:03 p.m., indicated "...The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely...." This citation relates to Complaint IN00439138. 3.1-19(f)(5)		place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. All staff were educated on infection control, proper handling of soiled linens on 11/09/2024 by IP/DNS/Regional IP. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Environmental QAPI developed to 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 DNS or designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	