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	10/20/2022

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 the Investigation of Complaints IN00389075, IN00390434, IN00391554, IN00392731 and IN00392868. Complaint IN00389075 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00390434 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00391554 - Unsubstantiated due to lack of evidence. Complaint IN00392731 - Substantiated. Federal/State deficiencies related to the allegations are cited at F694. Complaint IN00392868 - Unsubstantiated due to lack of evidence. Survey dates: October 18, 19 and 20, 2022. Facility number: 000147 Provider number: 155243 AIM number: 100266900 Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type: Medicare: 9 Medicaid: 62 Other: 26 Total: 97 This deficiency reflects State Findings cited in	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dean Earl Ramsey	Executive Director	11/01/2022

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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	accordance with 410 IAC 16.2-3.1. Quality review was completed on October 26, 2022.			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure physician's orders for a PICC (Peripherally Inserted Central Catheter) line were followed as written for 1 of 2 residents reviewed for a PICC line. (Resident K) Finding includes: On 10/19/22, concerns regarding Resident K's catheter and central line not being cared for during his entire admission at the facility was emailed into the Indiana Department of Health office by an anonymous person. The record for Resident K was reviewed on 10/20/22 at 4:30 p.m. Diagnoses included, but were not limited to, unspecified complications of an amputation stump, diabetes mellitus type 2 with diabetic neuropathy, non-pressure chronic ulcer of unspecified part of left lower leg, chronic kidney disease, stage 2 (mild) and psoriasis. The ETAR (Electronic Treatment Administration Record), dated 9/1/22 to 9/30/22, was reviewed. A physician's order, dated 9/2/22, indicated the PICC line dressing was to be changed as a sterile	F 0694	The facility respectful request a desk review for compliance. F694: Parenteral / IV Fluids SS=D What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Due to this being a compliant survey Resident K was not identified. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential of being affected. An audit of all central line / PICC lines was performed on 10/21/2022 for all residents in the facility. There were no adverse findings of dressing changes that were not in compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient Practice	11/02/2022

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	dressing change once a week on Fridays at 6:00 a.m. The following dates indicated the resident's PICC line dressing was not changed. On 9/09/22, there were no initials in the box. On 9/16/22, there was a nine (9) documented in the box. A nine documented in an ETAR box indicated "Other/See Progress Notes." There was no progress note documented, for 9/09/22, to indicate why the dressing change had not been done. A progress note, dated 9/16/22 at 4:05 p.m., indicated the PICC line dressing change was not changed due to RN 2 did not do it. No reason was documented. It was documented the RN had reported the dressing not being changed to the oncoming nurse. The ETAR, dated 10/1/22 to 10/31/22, was reviewed. A physician's order, dated 9/2/22, indicated the PICC line dressing was to be changed as a sterile dressing change once a week on Fridays at 6:00 a.m. The following dates indicated the resident's PICC line dressing was not changed: On 10/07/22, there was a five (5) documented in the box. A five documented in an ETAR box indicated "Hold/See Progress Notes." A progress note, dated 10/7/22 at 1:39 p.m., indicated the PICC line dressing change was not changed due to LPN 3 indicated the resident was over sedated and was not able to hold his arm up to allow her to change his dressing. A progress note, dated 10/8/22 at 3:18 a.m.,		does not recur: Education has been provided to all licensed care team members, including the policy of PICC / Midline / CVAD Dressing Change and Validation Checklist for PICC / Midline / CVAD Dressing Change. All orders for dressing change will be reviewed in morning meeting and checked for completion on each day following their scheduled day for completion. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The Unit Manager/or designee will audit daily Monday thru Friday x 30 days; then 3 x weekly x 8 weeks; then weekly x 8 weeks; then ongoing. Results will be shared and reviewed during the QAPI monthly meeting.	

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	indicated Resident K was being admitted to the hospital for sepsis and to rule out osteomyelitis. During an interview, on 10/20/22 at 4:40 p.m., RN 1 indicated if the ETAR box for a treatment was blank, the licensed person responsible for the treatment did not do it as ordered. If there was a number documented with the licensed persons initials, then the responsible licensed person wrote a note in the progress notes to explain why the treatment was not completed. During an interview, on 10/20/22 at 4:50 p.m., the ED (Executive Director) indicated he had no further information he could provide to show the PICC line dressings for Resident K had been changed as ordered. A current document, titled "PICC/Midline/CVAD/Dressing Change," undated and provided by the Interim DON (Director of Nursing) on 10/20/22 at 5:00 p.m., indicated "Policy: It is the policy of this facility to change peripherally inserted central catheter (PICC), Midline, or Central Venous Access Device (CVAD) dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Policy Explanation and Compliance Guidelines...Document the Procedure...." This Federal tag relates to Complaint IN00392731. 3.1-47(a)(2)			