STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155376	A. BUILDING 00 B. WING	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

(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. Survey dates: January 4, 5, 6, 9, 10, and 11, 2023. Facility number: 000336 Provider number: 155376 AIM number: 100290170 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 9 Medicaid: 60 Other: 9 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 24, 2023.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on 2/6/23.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lauren Kirkwood	HFA, RN	02/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on observation, record review and interview, the facility failed to ensure a resident's physician recommendations and comprehensive care plan were followed to reduce the risk of aspiration for 1 of 1 resident reviewed for quality of care. (Resident 53) Finding includes: During an observation, on 1/5/23 at 10:23 a.m., Resident 53 was observed lying in bed in a flat position. A sign on the wall indicated "elevate the head of bed." During an observation and interview, on 1/5/23 at 10:40 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident 53's bed was in the flat position and should be elevated to reduce the risk of aspiration. The record for Resident 53 was reviewed on 1/5/22 at 3:50 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, displaced fracture right femur, and neuralgia. A Kardex, dated 1/11/22, indicated staff were to ensure the head of the bed was elevated 30 degrees or higher due to the risk of aspiration. A care area assessment (CAA), dated 6/2/22, indicated Resident 53 had a functional limitation in range of motion, inability to perform activities of daily living without significant physical assistance, and a decrease ability to make self-understood or understanding others. His CAA lacked indication Resident 53 had a swallowing problem. A quarterly Minimum Data Set (MDS) assessment, dated 11/3/22, indicated Resident 53	F 0684	F 684 Quality of Care 1. HOB was immediately elevated 2. All residents with orders for HOB elevated had no other issues noted. 3. All nursing staff will be educated by DNS/Designee by 2/6/23 that residents with order for HOB elevated were followed. A current list with active residents provided to staff. 4. DNS/Designee will complete HOB tool 5x a week x 4 weeks, weekly x 4 weeks, and monthly x 4 months. The tool will be submitted to QAPI for review, or any further interventions needed. 5. Feb 6th 2023	02/06/2023

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	had exhibited no rejection of care. He required extensive physical assistance for personal hygiene. A care plan, with a revision date of 11/9/22, indicated Resident 53 had an alteration in nutritional status. Interventions included, but were not limited to, ensure the head of the bed was elevated at a 30-degree angle. A physician's assessment summary, dated 11/1/22, indicated it was recommended for the resident to be elevated at 90 degrees during oral intake and 45 minutes after meals, and he should always have the head of the bed no lower than 45 degrees at all times. A nutrition assessment, dated 11/3/22, indicated the resident had diet changes made due to dysphagia related to coughing and choking with meals and liquids. Resident 53 had a history of dysphagia. A Treatment Administration Record (TAR), dated 1/23, indicated Resident 53 was to have the head of the bed elevated to alleviate shortness of breath while lying flat in bed due to the diagnoses of dysphagia and the risk of aspiration. During an interview, on 1/6/23 at 2:30 p.m., the MDS nurse indicated she was responsible for updating the care plan when new recommendations from the physician came in. Resident 53's care plan did not reflect his head of bed was to be elevated to a 45-degree angle when he was not eating. During an interview, on 1/6/23 at 4:37 p.m., the Speech Therapist indicated Resident 53's head of bed should be elevated to a 30-to-45-degree angle			

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	at all times because of the risk of aspiration. He had been "throat clearing" a lot and even seemed to choke on saliva. A current policy, titled "Activities of Daily Living (ADL's) Supporting," indicated residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition. Staff were to provide assistance in care which included mobility and dining. 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure a medication cart was secured for 1 of 4 medication carts reviewed for medication storage. (100 Hall cart) Finding includes: During an observation, on 1/4/23 at 9:00 a.m., an unidentified nurse walked away from her medication cart facing the lounge. The medication cart was unlocked and had medication cards, a medication cup with pills inside, and an inhaler left on top of the medication cart. The medication cart was unlocked, and residents were seated in the lounge and walking around the area of the nurse's station. During an observation, on 1/04/23 at 10:30 a.m., Resident 76 was observed to wander up and down the 100 hallway. He walked up to the medication cart, at 10:31 a.m., and shook the top medication drawer. No staff were observed at the medication cart or in the nurse's station. Additionally, 12 other residents were observed seated in the lounge. During an observation, on 1/04/23 at 1:38 p.m., Registered Nurse (RN) 1 stood at the medication cart as she prepared medications for a resident. She grabbed the plastic medication cup and walked away with her back to both medication carts roughly 15 feet away where an unidentified resident was seated in a wheelchair. The medication cart was observed to be unlocked with the keys still in the medication cart. No staff were observed in the nurse's station or at the medication carts. 10 residents were observed seated in the lounge.	F 0761	F 761 Label/Store Drugs and Biological 1. Medication cart was secured immediately. 2. No other carts were identified to be unlocked during survey. 3. All nurses/QMAs will be educated on proper securing of medication carts by DNS/Designee by Feb 6th 2023. 4. DNS and Designee will complete Med Storage QAPI tool 5x week x 4 weeks, weekly x 4 weeks, and monthly x 4 months. Tool will be submitted to QAPI for review, or any further interventions needed. 5. Feb 6th 2023	02/06/2023

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During an observation, on 01/10/23 at 4:50 p.m., Licensed Practical Nurse (LPN) 2 was observed with her back to the medication cart more than 25 feet away near the dining room. A medication cart across from the lounge was observed unlocked. Nursing Assistant (NA) 4 was seated at the nurse station in front of the computer. Residents were observed in the lounge across from the unsecured medication cart.

The record for Resident 76 was reviewed on 9/30/22 at 9:56 a.m. Diagnoses included, but were not limited to, dementia, mood disorder, psychotic disorder, and major depression.

A care area assessment (CAA), dated 11/11/22, indicated he had behaviors of wandering and disorganized thinking.

A care plan, dated 9/19/22, indicated Resident 76 exhibited signs of cognitive impairment due to diagnosis of dementia and directed staff to intervene as indicated.

During an interview, on 1/10/23 at 4:45 p.m., the Executive Director indicated nursing staff should lock the medication carts and monitor to ensure the residents did not get into the carts.

A current policy, titled "Storage of Medication," dated of 11/20, indicated drugs were stored in locked compartments. Compartments including but not limited to drawers, cabinets, and carts are locked when not in use. Nursing staff are responsible for maintaining medication storage.

3.1-25(m)

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to label, date and store refrigerated and freezer foods, failed to prevent freezer burn, failed to date canned items when received, failed to date frozen meats when placed in the refrigerator to thaw, and failed to serve food in a sanitary manor. This deficient practice had the potential to effect 78 of 78 residents who received food from the kitchen. Findings include: During a kitchen observation, on 01/04/23 at 9:23 a.m., with the Kitchen Manager present the following was observed:	F 0812	F 812 Food Procurement, Store/Prepare-Sanitary 1. Unlabeled and unsealed items were immediately thrown out, freezer burnt items were immediately thrown out, unlabeled food cans were thrown out, and was immediately educated on proper sanitary serving. 2. No other issues noted. 3. All dietary staff will be educated by CDM/District Dietary Manager by 2/6/23 that all bags and packages must be sealed and dated if opened, freezer burnt	02/06/2023

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	1. In the dairy refrigerator: a. A large bag of shredded cheese was open, unsealed without an open date. b. 15 hot dogs were open, unsealed without an open date. 2. In the meat freezer: a. 20 frozen hamburgers were in a plastic bag unsealed. b. 20 pieces of fish were in a plastic bag unsealed. 3. Vegetable freezer: a. Two bags of frozen broccoli were frozen solid and were crunchy when touched. b. Two pork loin packages were defrosting in a pan on the bottom shelf without a date to indicate when they were placed in the refrigerator to thaw. 4. Dry storage area: a. Several food cans were not labeled with a receive date. During an interview, at that time, the Kitchen Manager indicated items in both the refrigerator and freezer should be labeled and dated when opened and placed in a sealable container. Freezer burnt items should be thrown away. All foods moved from the freezer to the refrigerator to defrost should be dated when moved over, and all canned food goods should be dated when they were received. 5. During a dining observation, on 1/4/23 at 12:19 p.m., Dietary Aide (DA) 1 touched his facemask twice then grabbed a dinner roll and a carton a milk without gloves and without sanitizing his hands. At 12:36 p.m., DA 1 touched the hood of his sweatshirt without sanitizing his hands. Again, at 12:38 p.m., DA 1 reached up and pulled		items are immediately disposed of upon discovery, items placed in refrigerator to thaw must be dated, all food cans are to be labeled with a receive date, and proper sanitary serving. 4. CDM/District Dietary Manager will complete audit tool 5x a week x 4 weeks, weekly x 4 weeks, and monthly x 4 months. The tool will be submitted to QAPI for review, or any further interventions needed. 5. Feb 6th 2023	

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	his mask away from his face and did not sanitize his hands. 6. During an observation, on 1/4/23 at 12:39 p.m., the Dietary Manager touched the back of his head and walked over to a resident drink cup filled with a red liquid and placed a plastic cover on the cup. The Dietary Manager was not observed to sanitize his hands before placing the cover on the cup. During an interview, on 1/6/23 at 9:46 a.m., the Infection Preventionist indicated she expected staff to wash or sanitize their hands after touching their face mask, hat, or hair. A current policy, titled "Food Storage" dated October 2018 and provided by the Executive Director on 01/09/23 at 11:52 a.m., indicated "...Open containers will be resealed in a manner that protects the remaining food product and will be dated with open date and a discard date on or before 30 days following opening....Items...will be dated with date of delivery and will be rotated/used following FIFO [first in first out]. A current policy, titled " Handwashing," undated, indicated staff should wash their hands as frequently as needed throughout the day following proper hand washing. 3.1-21(i)(1) 3.1-21(i)(3)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			

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	Based on observation, record review and interview, the facility failed to maintain a sanitary environment related to an accumulation of a black substance on the floors of the shower rooms and failed to maintain a clean, sanitary, and homelike environment for 1 of 1 resident and 2 shower rooms reviewed for environment. (North Shower, South Shower and Resident 53) Findings include: 1. During the Environmental Tour of the North Shower room, on 1/4/23 at 11:21 a.m., with Nursing Assistant (NA) 1 the following was observed: a. The wall of the shower room had multiple missing tiles on the wall near the toilet and exposed the sheet rock. b. The grout of the entire shower room floor was stained with a buildup of a black colored substance. During an interview, on 1/4/23 at 11:23 a.m., NA 1 indicated the grout was stained with a black substance. She indicated all residents in the North Hall used the shower room to bathe. After a resident gets a shower, the staff spray the shower walls down with a disinfectant solution. The housekeeping staff were responsible to clean the floors. 2. During the Environmental Tour of the South Shower room, on 1/4/23 at 2:40 p.m., with NA 5 the following was observed: a. The grout of the entire shower room floor was stained with a buildup of a black colored substance. b. A blue colored glove was found on the floor near the garbage can.	F 0921	F 921 Safe/Functional/Sanitary/Comfortable Environment 1. Shower room tile grout was immediately deep cleaned, Stanley Steamer came to steam clean grout, and bid was obtained to renovate all shower rooms. Glove and tan blanket were immediately picked up. Fall mat, broda chair and hoyer sling were immediately cleaned. 2. No other issues were identified. 3. All staff will be educated on expectations for Sanitary/Comfortable Environment including but not limited to shower cleaning, no items to be on shower room floor, and cleanliness of broda chairs/hoyer slings. 4. Environmental Director/ED will complete audit tool 5x week x 5 weeks, weekly x 4 weeks, and monthly x 4 months. Tool will be submitted to QAPI for review, or any further interventions needed. 5. Feb 6th 2023	02/06/2023

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	c. A tan colored blanket was found on the floor near two gray colored garbage cans. During an interview, on 01/06/23 at 3:08 p.m., the Executive Director indicated there was a cleaning schedule for the showers and they should be cleaned when scheduled. During an interview, on 1/6/23 at 3:22 p.m., the Director of Environmental Service indicated the floors were deep cleaned on Monday and Friday. The problem related to the grout was they need a deep scrub because the mop just pushed the dirt back and forth. He was aware of the missing tile on the wall of the shower room. 3. During an observation, on 1/4/23 at 10:30 a.m., Resident 53 was observed lying in bed with the fall mat next to the bed. The fall mat had a 10-inch dry clear stain on the left lower corner and multiple other stained areas throughout the area. During an observation, on 1/5/23 at 9:19 a.m., Resident 53 was seated, in his Broda chair, near the nurse's station. His Broda chair had dried food stains on the arms and sides of the chair. During an observation, on 1/6/23 at 9:12 a.m., Resident 53's Broda chair was visibly soiled with dry, yellow-colored stains on the left side. His blue colored fall matt positioned next to the bed had multiple areas of dirty dry shiny areas. The Hoyer sling found on the seat of the Broda chair had a large amount of food crumbs scattered across the fabric. During an interview, on 1/10/23 at 10:07 a.m., the Executive Director indicated her expectation for staff if they see something, they should clean it. Everyone was responsible for ensuring the			

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	resident rooms and equipment was clean. A current policy, titled "Cleaning and Disinfection of Resident Care Items and Equipment," dated 10/18, indicated resident care equipment would be cleaned and disinfected according to current CDC recommendations for disinfection. 3.1-19(f)(5)			