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	08/16/2023

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 Complaint IN00413177. Complaint IN00413177- Federal/State deficiencies related to the allegations are cited at F550. Survey dates: August 9, 10, 11, 14, 15 and 16, 2023 Facility number: 000147 Provider number: 155243 AIM number: 100266990 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 3 Medicaid: 79 Other: 4 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed August 29, 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 any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **The provider alleges compliance as of 09/21/2023.The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brian Lessley | Administrator | 09/20/2023

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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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure incontinence care was provided and the residents were free from negative comments by staff for 2 of 2 residents reviewed for dignity. (Resident C and F)	F 0550	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. For both residents C and F, the employees involved in the	09/11/2023

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	Findings include: 1. During an interview, on 8/10/23 at 2:44 p.m., Resident C indicated during the second shift she had her call light on. Certified Nursing Assistant (CNA) 3 came to the door and told the resident she was just changed about 10 minutes ago, and she would come back in 2 hours and change her. The resident told CNA 3 she had a bowel movement and told her she needed to be changed. CNA 3 walked in the room, turned the call light off, and told the resident she only had to change her every two hours and left the room. The record for Resident C was reviewed on 8/14/23 at 3:45 p.m. Diagnoses included, but were not limited to, clostridium difficile colitis (inflammation of the colon caused by bacteria which causes diarrhea), diabetes mellitus, and fracture of the upper end of the left humerus (the largest bone of the upper arm). A physician's order, dated 8/1/23, indicated the resident was to be placed in contact isolation precaution (for patients who have germs which could spread by touching the patient or surfaces in their rooms) for clostridium difficile colitis. A care plan, dated as revised 8/1/23, indicated the resident had impaired skin integrity from a coccyx pressure ulcer. The goal included to check for incontinence and provide incontinence care as needed. A care plan, dated as revised 8/3/23, indicated the resident had diarrhea, loose stools, and was positive for clostridium difficile colitis. The goal included to assist with peri care as needed and assist with incontinence care as needed.		allegations have been completely removed from their care. 2. 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. All residents have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Care plans were reviewed for residents that are care in pairs to ensure the care plan reflects the care provided. The state definitions of Abuse, Neglect and Exploitation will be reviewed with the Administrator (Exhibit A). Abuse Training was provided to all staff and is provided during orientation of all new employees (Exhibit B) The facility policy for investigation of Abuse, Neglect and Exploitation will be reviewed with the Administrator. Prior to the completion of an investigation of allegations of abuse, the administrator or designee will use a comparative check list (Exhibit C) to ensure requirements of the facility policy have been followed and the of abuse, neglect and exploitation, as they apply to the investigated incident, have been met. All Staff will be trained on Resident Rights (Exhibit E) Open investigations will be reviewed in the daily stand-up meeting to ensure all information is collected	

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	A care plan, dated as revised 8/3/23, indicated the resident had episodes of incontinence of bladder and bowels. The goal included to assist with routine toileting as needed and check routinely for incontinence and provide incontinence care as needed. A Facility Incident Report indicated, on 8/9/23, Resident C indicated a staff member entered the room to answer her call light and stated, "I'm not coming in again for another 2 hours" A statement from LPN 9 indicated, on 8/8/23 at approximately 7:45 p.m., LPN 9 went to administer medication to the resident. She asked why the call light was on. The resident told the nurse things were not working out at the facility. The resident was told the call light would only be answered every 2 hours. The resident became teary explaining at 5:45 p.m., Resident C asked to be changed due to being incontinent. CNA 3 told the resident the call light was just answered by another CNA and the resident did not need to be changed and she would be back in 2 hours. The resident complained of burning due to not being changed. A Certified Nursing Assistant (CNA) job description, signed on 7/18/22, by CNA 3 was reviewed. The position summary indicated the CNAs were to respond to resident's call lights to provide maximum comfort, safety, and privacy. Treat all residents with kindness, respect and dignity and the CNA must demonstrate empathy, courteous, kind, and professional workplace behavior and customer services to all residents, care team members, vendors, visitors, and family members at all times. During an interview, on 8/14/23 at 12:26 p.m., Resident C indicated CNA 3 was still working and had worked her unit again on 8/12/23. She was		and the investigations are correct and complete. Staff will be inserviced on incontinent care. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. A resident roster will be printed each week and residents on that roster will be interviewed as to whether they are experiencing or witnessing abuse, such that all interviewable residents will be interviewed (Exhibit ZZ). This will be done weekly for 1 month, bi-weekly for two months and at least monthly for four months.	

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	shocked to see the CNA was still caring for her. She had her call light on, and CNA 3 entered the room, turned the call light off, and left. The resident was incontinent and needed to be changed. During an interview, on 8/14/23 at 4:33 p.m., the Executive Director (ED) indicated he had not heard anything about the new complaint from Resident C. He indicated, to the Director of Nursing (DON), he thought the CNA was taken off Resident C's assignment. During an interview, on 8/14/23 at 4:35 p.m., the DON indicated she was in the resident's room earlier and the resident did say anything to her about CNA 3. The DON indicated the CNA worked the hall on Saturday. During an interview, on 8/15/23 at 10:29 a.m., LPN 9 indicated she worked with CNA 3 on 8/8/23. LPN 9 went to give Resident C's her medication and noticed the call light was on. LPN 9 asked why the call light was on and was told the resident asked to be changed two hours ago. CNA 3 indicated the resident was just changed and she did not have to change the resident for another two hours. CNA 3 had turned the call light off and left the room. Resident C had a bowel movement and was sitting in a dirty brief for two hours. The resident had clostridium difficile colitis and was incontinent. LPN 9 had heard CNAs were tired and frustrated from changing the resident. During an interview, on 8/15/23 at 4:51 p.m., CNA 2 indicated she could not get the resident's care completed and answering call lights was stressful. CNA 2 indicated she was working with CNA 3 today and was not aware of any CNAs who could not go into Resident C's room. Resident C had			

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	clostridium difficile colitis and asked to be changed a lot. During an interview, on 8/16/23 at 10:41 a.m., the Executive Director (ED) indicated he did not start another investigation for the complaint the resident made for 8/12/23. CNA 3 might have gone into the resident's room however CNA 3 indicated to the ED she did not go into the room. 2. During an interview, on 8/09/23 at 2:29 p.m., Resident F indicated there was a CNA who was mean to her and was not supposed to be entering her room. During a care plan meeting, the resident and the facility had discussed CNA 7 not entering her room. During an interview, on 8/11/23 at 12:31 p.m., the resident indicated CNA 7 had cared for her for several days after the care plan meeting. The CNA made rude comments and stated the dolls in her room were ugly. The resident was tearful and was still distressed with the care provided by the CNA. The record for Resident F was reviewed on 8/11/23 at 11:07 a.m. Diagnoses included, but were not limited to, cerebral palsy, major depressive disorder, muscle weakness, and anxiety. A care plan meeting, dated 7/20/23 at 10:36 a.m., indicated the resident had an issue with one of the caregivers and she was rude. The Nursing Director would address the issue. A written statement, dated 7/21/23, indicated CNA 7 was reminded sarcastic jokes and comments could be misunderstood. The CNA was taken off the resident's care assignment.			

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	During an observation, on 8/15/23 at 10:38 a.m., the assignment sheet at the nurse's station indicated CNA 7 was assigned to the Resident F. During an interview, on 8/15/23 at 10:39 a.m., CNA 7 confirmed the assignment listed on the board was correct. CNA 7 was not removed from the assignment as indicated in the written statement. During an interview, on 8/15/23 at 2:04 p.m., the ADON (Assistant Director of Nursing) indicated she was aware the resident had issues with CNA 7. The solution was to use a buddy system so the CNA was not in the room alone with the resident. She was not aware the resident was still distressed with the care provided from the CNA. During an interview, on 8/16/23 at 11:59 p.m., the Executive Director indicated he knew CNA 7 was rude to the resident and they had a care plan meeting to discuss the issue. The DON indicated the CNA was known to make jokes towards the resident but was not aware of the CNA calling her dolls ugly. The intervention to the problem was to care for the resident in pairs of staff instead of a single staff member taking care of the resident, although the resident did not have a care plan for caring in pairs. The Executive Director and DON indicated there was no investigation done for this issue. A psychiatric progress note, dated 8/2/23, indicated the clinician reviewed a behavioral health note, dated 7/28/23, which indicated the CNA continued to make fun of her dolls and was calling them ugly. The resident did not like being cared for by the CNA.			

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	A current policy, titled "Abuse Prevention Program," dated as reviewed in March 2021 and received at entrance conference indicated "..."Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability..."Mental abuse" is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services...." This Federal tag relates to Complaint IN00413177. 3.1-3(a) 3.1-3(t) 3.1-3(v)(1)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.			

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	(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on record review and interview, the facility failed to ensure resident council grievances had a response for 7 of 7 months reviewed for resident council grievances. (January 2023 through July 2023) Findings include: The resident council meeting minutes were reviewed, on 8/14/23 at 1:00 p.m., for the months of January 2023 through July 2023. The resident council meeting minutes, dated January 2023, indicated there were concerns the call lights and medication pass took too long, showers were not consistent, food portions were still too small, the kitchen did not follow the menus, the rooms needed cleaned, soap and toilet paper needed refilled, clothes were lost, and	F 0565	ol class="NumberListStyle1 SCXW226468760 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. p paraid="1074585105" paraeid="{ac2aceac-06da-454c-83c7-b67006cb453f}{168}" >The resident council minutes for January February, March, April, May, June and July will be reviewed for outstanding	09/11/2023

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	rooms needed to be mopped. There were no documented responses. The resident council meeting minutes, dated February 2023, indicated there were concerns the call light responses were too long, CNAs had bad attitudes especially at night (overnight), showers were missed and residents were not asked about showers, small portions were served, meals were late, cold food was served at meals, clothes were lost, clothes weren't returned regularly, rooms were not cleaned, toilets were not cleaned, and television remotes were needed. Social Service was not following up on grievances, her door was never opened, and she was difficult to find. There were no documented responses. The resident council meeting minutes, dated March 2023, indicated there were concerns the call lights still took too long to answer, showers were a problem, showers were not given as scheduled, nursing was not ordering medications on time, continued to receive cold food, not following the menus, never knew what would be served at meals, clothes were lost, bleach stains were on the clothes, not receiving personal clothing back with any regularity. Social Service needed to be available and follow up on grievances. There were no documented responses. The resident council meeting minutes, dated April 2023, indicated the wheelchairs were dirty, water was not getting passed, the shower rooms were filthy, needed adequate dining room staff for meals, needed to serve snacks to the residents, would like follow up chat for medical issues and needed wound care 7 days a week, there were not always condiments on the cart, the meats were tough and hard to chew, portions were small, fried eggs, bacon and sausage for breakfast were		unaddressed issues review all of them in an ad hoc resident council meeting scheduled with the permission of the Resident Council President. All issues considered to be unresolved at that point or any resident specific issues that are unresolved will be escalated to the IDT to be addressed within 1 week of the meeting. 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. All residents have the potential to be affected by the practice. ol class="NumberListStyle1 SCXW226468760 BCX8" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" That measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	inconsistent, would have liked to have Gatorade and soup for residents who were not feeling well, needed more active activities, laundry was not taken from rooms, windows needed cleaned, needed toilet paper in rooms and rooms needed mopped, closet doors needed fixed and temperatures needed regulated. There were no documented responses. The resident council meeting minutes, dated May 2023, indicated the resident felt like adaptive equipment was a problem, the food was cold, the menu was inconsistent or wrong, there was no alternate menu, there were not always anytime menu items, the food orders were wrong, there was no cake/dessert, the food quality was poor, serving size was not correct, would have liked ice cream in the evening, toilet needed cleaned in room 137, bathroom floors needed cleaned daily, laundry was missing, the clothing was mixed up and not to given to the correct resident, showers were not correct, staff finished serving meals and disappeared, the night aides were unfriendly and didn't help with residents, the shower rooms were filthy, and call light responses were long. There were no documented responses. The resident council meeting minutes, dated June 2023, indicated p.m. snacks were not served, needed the dining room staffed, last trays served usually were cold, the shower rooms needed cleaned better, cleaned wheel chairs not getting dried off, needed water passed, bathroom call lights wait were greater than 2½ hours, staff were sleeping in the lounge, staff were on the phone and not answering call lights, staff attitudes were bad, staff walked out and called in way too much, showers were not happening a lot of times, visits were not happening for some due to smells, some residents didn't know shower times, residents had		All concerns stemming from resident council and recorded in the minutes will be reviewed in the daily stand-up meeting by the administrator or designee with the interdisciplinary team and flow into the grievance procedure when necessary (Exhibit H) All outstanding concerns not addressed after 1 week will be escalated to the Executive Director for immediate intervention and resolution. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Outstanding concerns through the resident council will be addressed as a percentage in the QAA meeting to monitor compliance with 100% resolution of concerns raised through the Resident Council for a period of 6 months and monthly there after until 100% compliance is achieved for a minimum of 3 consecutive months.	

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	concerns about the stand lift, resident were not getting pain medications timely, there complaints regarding specific staff members-horribly mean to residents, must wait for help and medications until time for staff to leave, playing on phone instead of putting residents to bed who were in pain, CNAs wouldn't help with ted hose. A note at the bottom of the council minutes indicated the residents did not want their names given to the staff they complained about. There were no documented responses. The resident council meetings minutes, dated July 2023, indicated a deep clean schedule was needed, and to put everything (belongings) back when completed, paper towels needed to be stocked, residents were sometimes cleaning their own rooms, trash needed emptied, closet doors needed repaired, building temp needed regulated, the blinds were dirty and were not working in some rooms, and requested to know how long to follow up on grievances. One response from Social Service indicated it would be a 2-4-day response for Social Services to follow-up. There were no other documented responses. During an interview with residents who regularly attended resident council meetings, on 8/15/23 at 2:00 p.m., the resident council president, Resident 34, Resident 23 and 22, who attend routinely, indicated the responses to grievances and resident concerns were not responded to in a timely manner or the concerns are not addressed at all. A current policy, titled "Resident Council Meetings," not dated and received from the Human Resource on 8/16/23 at 4:03 p.m., indicated "...the facility shall act upon concerns and recommendations of the council, make attempts to			

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	accommodate recommendations to the extent practicable and communicates its decisions to the council...." 3.1-3(l)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to fully investigate an allegation of abuse for 2 of 5 residents reviewed for abuse. (Resident C and F) Finding includes: 1. During an interview, on 8/10/23 at 2:44 p.m., Resident C indicated during second shift (2-10 p.m.) her call light was on. CNA 3 came to the door and told the resident she was changed about 10 minutes ago, and she would come back in 2 hours and change her. The resident told CNA 3	F 0610	ol class="NumberListStyle1 SCXW20630738 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. For both residents C and F, the	09/11/2023

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	she had a bowel movement and she needed to be changed. CNA 3 walked in the room, turned the call light off, and told the resident she only had to change her every two hours then CNA 3 left the room. The record for Resident C was reviewed on 8/14/23 at 3:45 p.m. Diagnoses included, but were not limited to, clostridium difficile colitis (inflammation of the colon caused by bacteria which causes diarrhea), diabetes mellitus, and fracture of the upper end of the left humerus (the largest bone of the upper arm). A Facility Incident Report indicated, on 8/9/23, Resident C indicated a staff member entered the room to answer her call light and stated, "I'm not coming in again for another 2 hours" A statement from LPN 9 indicated, on 8/8/23 at approximately 7:45 p.m., LPN 9 went to administer medication to the resident. She asked why the call light was on. The resident told the nurse things were not working out at the facility. The resident was told the call light would only be answered every 2 hours and not sooner. The resident became teary explaining, at 5:45 p.m., she asked to be changed due to being incontinent of bowel. CNA 3 told the resident the call light was just answered by another CNA and the resident did not need to be changed. The CNA would be back in 2 hours. The resident complained of burning due to not being changed. During an interview, on 8/16/23 at 11:40 a.m., the Executive Director (ED) indicated he was not aware of what the policy for abuse stated about completing investigations for alleged abuse and he did not interview staff on all shifts. CNA 3 was given disciplinary actions. The CNA was not assigned to Resident C. CNA 3 would have given		employees involved in the allegations have been completely removed from their care. 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. ·All residents who are the subject of an investigation of an allegation of abuse against them by staff or other residents have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The facility policy for investigation of Abuse, Neglect and Exploitation will be reviewed with the Administrator. Abuse Training was provided to all staff and is provided during orientation of all new employees (Exhibit B) The state definitions of Abuse, Neglect and Exploitation will be reviewed with the Administrator (Exhibit A) Prior to the completion of an investigation of allegations of	

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	care to Resident C if the other CNA was on break. After investigating the incident, he determined the complaint was more of a customer service problem and not abuse. The staff got frustrated due to the amount of time the light went on and it was not appropriate for CNA 3 to say she would not go in the room more frequently than every two hours. The frequency of response was based on the resident's need and every 2 hours was just the minimum. When asked the difference between customer service and abuse he indicated it had to do with the content of what was said, the resident response, and whether there was intent. The CNA was acting out of frustration, she did not say she would not give the care and was not going to give it at the time. The investigation did not include the resident received the care.2. During an interview, on 8/09/23 at 2:29 p.m., Resident F indicated there was a CNA who was mean to her and was not supposed to be entering her room. During a care plan meeting, the resident and the facility had discussed CNA 7 not entering her room. During an interview, on 8/11/23 at 12:31 p.m., the resident indicated CNA 7 had cared for her for several days after the care plan meeting. The CNA made rude comments and stated the dolls in her room were ugly. The resident was tearful and was still distressed with the care provided by the CNA. The record for Resident F was reviewed on 8/11/23 at 11:07 a.m. Diagnoses included, but were not limited to, cerebral palsy, major depressive disorder, muscle weakness, and anxiety. A psychiatric progress note, dated 8/2/23, indicated the clinician reviewed a behavioral health note, dated 7/28/23, which indicated the CNA continued to make fun of her dolls and was		abuse, a comparative check list (Exhibit C) to ensure requirements of the facility policy have been followed and the definitions of abuse, neglect and exploitation, as they apply to the investigated incident, have been met. p paraid="1709384435" paraeid="{be4c1012-b947-44cb-b532-c29231d6337c}{107}" >Open investigations will be reviewed by the administrator with the IDT team in the daily stand-up meeting to ensure all information is collected and the investigations are correct and complete (Exhibit D). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The content and completeness, and timeliness of all state reported incidents will be reviewed in the QAA meeting for a period of 6 months.	

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	calling them ugly. The resident did not like being cared for by the aide. During an interview, on 8/16/23 at 11:59 p.m., the Executive Director (ED) and Director of Nursing (DON) indicated it was known CNA 7 was rude to the resident. The facility did not complete an investigation for potential abuse and did not interview other staff and residents. A current policy, titled "Abuse Prevention Program," dated as revised on 3/2018 and received at entrance conference indicated, "...When an incident of resident abuse is alleged, suspected, or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred...Abuse Investigations...Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident...Interview the resident's roommate, family members, and visitors...." 3.1-28(d)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record	F 0679	ol class="NumberListStyle1	09/11/2023

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	review, the facility failed to provide consistent and resident preferred activities for 4 of 4 residents reviewed for activities. (Resident 15, 79, 63 and 41) Finding includes: 1. During an observation and interview, on 8/9/23 at 1:29 p.m., the Resident 15 was lying in bed in her room. She indicated she wanted to go to activities although she could not since the staff were not getting her up in her chair. It had been nine weeks since the resident got to attend activities outside of her room. During an observation, on 8/11/23 at 11:11 a.m., the resident was lying in bed in her room. During an observation, on 8/11/23 at 3:54 p.m., the resident was lying in bed in her room. The record for Resident 15 was reviewed on 8/15/23 at 3:47 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, chronic respiratory failure, and chronic congestive heart failure. A care plan, dated 8/9/21 and revised on 1/31/23, indicated the resident preferred to be involved in small and large group activities. The resident preferred bingo, Pokeno, jackpot, bracelet making, and interacting with peers, family, and team members. An activity log, dated July 2023, indicated the resident had one to one visit on 7/6, 7/19 and 7/28/23. The resident had 3 activities documented for the month of July 2023.		SCXW214813115 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1:1 group activities will be scheduled and implemented for resident 15. Resident 15 will be interviewed to ascertain her activities preferences at the present time and a routine schedule developed to meet her needs. Resident 79 will be provided with in room activities per their preference such as books, newspaper and magazines to read. 1:1 activities will be scheduled and implemented for resident 79. Resident 63 will be interviewed to ascertain her activities preferences at the present time, and arrangements will be made to allow for to be transported to and participate in group activities. 1:1 activities will be provided for resident 41. Resident 41 will be escorted to group activities and provided a monthly calendar.	

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	An activity log, dated August 2023, indicated the resident had one to one visit on 8/3, 8/5 and 8/9/23. The resident had 3 activities documented for the month of August 2023. The activity logs did not include any activities other than one to one visit. During an interview, on 8/9/23 at 1:40 p.m., RN 8 indicated the resident had not been out of bed for 2 weeks because she did not have a suitable chair to sit in. During an interview, on 8/15/23 at 3:10 p.m., the Unit Manager indicated the resident had not been out of bed for several weeks. She previously used a power chair and was determined to not be safe to use the power chair and did not have an alternate chair to use.2. The record for Resident 79 was reviewed on 8/10/23 at 3:19 p.m. Diagnoses included, but were not limited to, delusional disorder, severe dementia without behavioral disturbance, psychotic disturbance or mood disturbance, and anxiety. During an observation, on 8/9/23 at 1:34 p.m., the resident was in her room. There were no books, magazines or newspapers in the room and no activities observed. During an observation, on 8/10/23 at 3:19 p.m., the resident was in bed with her eyes opened. The television was on with no activities noted and no books, magazines, or puzzles in the room. During an observation, on 8/14/23 at 10:20 a.m., the resident was sitting on the side of her bed.		ol class="NumberListStyle1 SCXW214813115 BCX8" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 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. All residents have the potential to be affected by the practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Group and 1:1 activities logs will be reviewed weekly in the daily stand up meeting for completeness and consistency by the Activities Director or designee All residents care planned for 1:1 visits will be reviewed to ensure the logs reflect regular 1:1 activity visits (Exhibit I) ol class="NumberListStyle1 SCXW214813115 BCX8"	

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	The television was not on and there were not books or magazines in the room and no staff interaction. During an observation, on 8/14/23 at 12:15 p.m., the resident was lying in bed with her eyes opened. The room was dimly lit, and the television was not on. A care plan, dated 6/19/2023, indicated the resident required room visits or one on one activity due to being on hospice and wanting to have one on ones instead of attending activities. The Minimum Data Set (MDS) assessment, dated 6/19/23, indicated it was very important for the resident to have books, newspaper, and magazines to read. The Activity Participation log for the month of July 2023 indicated one to one activity had been completed on 7/6, 7/10, 7/11, 7/16, 7/17, 7/18m 7/22 and 7/29. The resident had one to one activity 8 of 31 days. The Activity Participation log for the month of August 2023 indicated the resident refused activities on 8/1 and had one to one activity on 8/8 and 8/11/23. The resident only had two activities marked for the month of August. During an interview, on 8/14/23 at 12:15 p.m., the resident indicated no staff had been there to read or talk to her. During an interview, on 8/9/23 at 3:18 p.m., the Director of Nursing (DON) indicated the facility had no activity staff and all staff were assisting to		role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Group and 1:1 activities logs will be reviewed in the QAA meeting for completeness and consistency. All residents care planned for 1:1 visits to ensure the logs reflect regular 1:1 activity visits are occurring. To be reviewed in QAA for 6 months.	

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	provide activities until they could get new activity staff. The previous staff had left the position with short notice. During an interview, on 8/14/23 at 11:39 a.m., the Assistant Director of Nursing (ADON) indicated the Activity Log documentation had multiple blank spaces and she did not know what the blank spaces meant. If the blank spaces were nursing documentation it would indicate nothing happened.3. During an observation and interview, on 8/09/23 at 1:58 p.m., Resident 63 was sitting in her room with the door shut. The resident indicated she enjoyed activities but the staff quit and now she stayed in her room except to go to dialysis. The resident was not reminded of the activities, and needed someone to take her. The CNAs told her they were too busy. The record for Resident 63 was reviewed on 8/14/23 at 11:53 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic pulmonary edema, dependent on renal dialysis, hypertension, cardiac pacemaker, and macular degeneration. A care plan, dated as revised on 8/9/23, indicated the resident was to be involved in group activities. The goal included to provide assistance or escort to activity functions, provide verbal reminders of time and place of activity. The Activity Participation Follow Up Question Report, for 7/1/23 to 8/15/23, indicated activities did not occur from 8/8/23 to 8/15/23. The resident had 8 days of no documented activities. During an interview, on 8/10/23 at 2:40 p.m., the DON indicated the activity staff left and at the time they had no Activity Director.			

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	4. During an observation, on 8/09/23 at 1:49 p.m., Resident 41 was sitting in her high back wheelchair alone in her room facing the wall. The resident had no television or music playing. During an observation, on 8/10/23 at 9:33 a.m., the resident was sleeping in her wheelchair at the nurse's station. During an observation, on 8/11/23 at 10:22 a.m., the resident was sitting in her wheelchair at the nurse's station with the right side of her wheelchair up against the wall. During an observation, on 8/14/23 at 12:22 p.m., the resident was sitting in her wheelchair at the nurse's station with eyes closed. During an observation, on 8/15/23 at 9:44 a.m., the resident was sitting in her wheelchair sleeping. The record for Resident 41 was reviewed on 8/11/23 at 10:27 a.m. Diagnoses included, but were not limited to, anxiety disorder, schizoaffective disorder, and depressive order. A care plan, dated as revised on 8/9/23, indicated the resident would receive one on one activities three times a week. The goal included was to provide assistance or escort to activity functions and provide monthly activity calendar. The Activity Participation Follow Up Question Report, for 7/1/23 to 8/15/23, indicated activities did not occur from 7/30/23 to 8/15/23. The resident had 16 days of no documented activities. During an interview, on 8/15/23 at 10:49 a.m., the Cedarwood Unit Manager indicated she normally			

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	had the CNAs lay the resident down after each meal. She asked the CNAs to lay her down and they have not. The resident had one on one visits for activities. During an interview, on 8/15/23 at 2:47 p.m., the DON indicated the activities participation report was the only information they had on the resident. She was not sure if any activities happened after the last date on the report. A current policy, titled "Individual Activities and Room Visit Program," dated as revised on 7/2018 and received from the DON on 8/14/23 at 11:50 a.m., indicated "...Individual activities will be provided for those residents whose situation of condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities...the activities program provides individualized activities consistent with the overall goals of an effective activities program...It is recommended that residents on a room visit program receive, at a minimum, three room visits per week. Typically, a room visit is ten to fifteen minutes in length...." A current policy, titled "Activities Attendance," dated as revised on 6/1/18 and received from the DON on 8/15/23 at 4:18 p.m., indicated "...The Activity Department records activities attendance and participation of all residents...Attendance and participation is recorded for every resident in group and individual activities daily. Documentation may be in paper form or in the electronic medical records...Records are reviewed on a regular basis to determine any changes in resident participation that might indicate a change in condition and lead to reassessment and care plan review...Attendance records are used when completing residents' progress notes to determine			

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	their participation as it relates to their activity plan...." 3.1-33(a) 3.1-33(b)(8)			
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. Based on observation, interview and record review, the facility failed to ensure a resident's care was coordinated with Hospice staff for obtaining a positioning chair and to document follow-up for a resident with left arm swelling for 2 of 2 residents reviewed for Hospice. (Resident 5 and 15) Findings include: 1. During an observation, on 8/10/23 at 10:36 a.m., Resident 5 had left arm swelling on the side where her dialysis fistula was located. The resident's right arm was much smaller than the left arm. The record for Resident 5 was reviewed on 8/15/23 at 3:47 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, chronic respiratory failure, and chronic congestive heart failure. A physician's order, dated 7/6/23, indicated the	F 0684	p paraid="1681277245" paraeid="{1851347b-7479-48bc-8bf4-a2f0416a53fd}{81}" >1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 5 successfully underwent 8/17/23 fistula graft procedure with angioplasty related to stenosis. The swelling has resolved. Resident 15 is no longer on hospice services per her wishes and the facility has provided her with a wheelchair of appropriate size. 2. How other residents having the	09/11/2023

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	155243	A. BUILDING 00 B. WING	08/16/2023

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
	resident had a dialysis fistula located in the left arm and to check the fistula every shift for thrill (feeling the motion of blood with the fingers) and bruit (a whooshing sound), swelling, pain, change in temperature, and/or bleeding. A progress note, dated 8/11/23 at 1:44 p.m., indicated the resident was resting in bed. The dialysis fistula had bruit and thrill present. There were no signs or symptoms of infection and no complaints of pain. A post dialysis communication, dated 8/11/23 at 10:30 p.m., indicated the resident's left arm was swollen, warm and reddened. The resident had an appointment to address this. The note did not include when or where the appointment to address the left arm swelling would happen. The electronic record did not include any further information about the left arm including if the arm was the same or the condition was worse. During an interview, on 8/16/23 at 3:20 p.m., the Assistant Director of Nursing (ADON) indicated the resident was in the emergency room for refusing dialysis. The dialysis staff had written the note about the swelling in the left arm, on 8/11/23, and they had scheduled a follow up appointment about the arm. The facility staff had no other documentation in the electronic record about the swelling or condition of the resident's left arm. The ADON did not have information about when the follow up appointment was or who would be doing the follow up appointment. 2. During an observation, on 8/9/23 at 1:29 p.m., Resident 15 indicated the hospice staff wanted to		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All residents admitted to hospice services will be scheduled an IDT care plan within 72 hours (Exhibit N) All hospice providers active in the facility will be required to update the hospice care binder each week (Exhibit L) All acute changes in residents will be captured on a 24 hour report to monitor required follow up. The DNS, or designee, will confirm that hospice binders are updated weekly. The DNS, or designee, will review 24 hour reports five days a week to ensure appropriate follow up. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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	get her up in her chair today and the facility staff said no. She did not know if the staff were getting her a different chair. During an interview, on 8/9/23 at 1:40 p.m., RN 8 indicated the hospice staff was present to assist the resident to get up in the chair and the facility staff told hospice not to get the resident up. The hospice staff was supposed to get a more suitable chair for the resident. RN 8 did not know when the hospice staff would bring the chair. The resident had not been out of bed for 2 weeks because she did not have a suitable chair to sit in. During an observation, on 8/11/23 at 11:11 a.m., the resident was lying in bed in her room. During an observation, on 8/11/23 at 3:54 p.m., the resident was lying in bed in her room. The record for Resident 15 was reviewed on 8/11/23 at 11:23 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic pulmonary edema, chronic obstructive pulmonary disease, congestive heart failure, need for assistance with personal care, osteoarthritis, and low back pain. A progress noted, dated 8/3/23 at 10:56 a.m., indicated the hospice staff were present and admitted the resident to their hospice services. A care plan, dated 8/3/23, indicated the resident was receiving hospice services due to heart failure. The interventions included, but were not limited to, hospice care per hospice care plan and nursing facility to provide required care in the absence of hospice personnel. The hospice binder only included admission		i.e., what quality assurance program will be put into place. The audit of the hospice binders and trending of acute care changes will be reviewed in the QAA meeting for 6 months (Exhibit M)	

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	paperwork and a staff sign in sheet. There were no progress notes in the binder and no information on the care provided or equipment requested for the resident. There was no hospice care plan in the binder. During an observation, on 8/15/23 at 2:41 p.m., the resident was lying in bed in her room, her eyes were closed, and the head of the bed was elevated. During an interview, on 8/15/23 at 3:01 p.m., the Unit Manager (UM) indicated the resident was having positioning issues while up in a chair. Prior to the resident's decline, she had a power chair and was determined to not be safe to use the chair. The UM was not aware hospice was going to get the resident another chair and would contact them. The electronic chart did not have information about hospice getting a positioning chair for the resident and the hospice binder had no progress notes in it at all. The UM called the hospice agency and the hospice agency asked what type of chair the facility wanted for the resident. They did not have information prior to the call about getting the resident a chair for positioning. The UM requested the hospice progress notes for the facility hospice binder since they did not have them. A current policy, titled "Charting and Documentation," dated as revised July 2017 and received from the Executive Director (ED) on 8/16/23 at 4:33 p.m., indicated "...All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the			

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	interdisciplinary team regarding the resident's condition and response to care...Documentation in the medical record may be electronic manual or combination...The following information is to be documented in the resident medical record...Objective observations...Treatments or services performed...Changes in the resident's condition...Events, incidents or accidents involving the resident...Progress toward or changes in the care plan goals and objectives...Documentation in the medical record will be objective...complete, and accurate...." A Hospice agreement, not dated, indicated "...'Hospice Services' means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include but are not limited to...nursing care and services by or under the supervision of a registered nurse...medical social services provided by a qualified social worker under the direction of a physician...medical supplies...use of medical appliances...The Plan of Care must reflect Hospice patient and family goals and interventions based on the problems identified in the Hospice patient assessments...The Plan of Care will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes...an identification of the Hospice Services...." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a			

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	resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, record review and interview, the facility failed to ensure a resident had on a splint as ordered by the physician and to ensure a resident had a palm protector as ordered by the physician for 1 of 4 residents reviewed for limited range of motion. (Resident 14 and 57) Findings include: 1. During an observation, on 8/9/23 at 1:12 p.m., Resident 14 was observed to have a contracted right hand and did not have a splint in place. During an observation, on 8/11/23 at 11:16 a.m., the resident was in her wheelchair and was propelling herself in the hallway. The resident did not have a splint on her right hand. The record for Resident 14 was reviewed on 8/11/23 at 3:02 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis) and hemiparesis (weakness) following unspecified	F 0688	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 14 was observed to have a contracted right hand, a physician order for a splint, and did not have a splint in place. Staff were educated on the requirement and use of the splint for resident 14 and the splint was applied per physician orders. Staff were educated on the requirement and use of the palm protector for resident 57 and the palm protector was applied per physician orders. 2. How other residents having the potential to be affected by the same deficient practice will be	09/11/2023

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	cerebrovascular disease affecting the right dominant side, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and vascular dementia. A care plan, dated 8/24/21, indicated the resident needed assistance with activities of daily living related to impaired mobility, limited range of motion to the right upper extremity, and hand and wrist contractures. A physician's order, dated 9/1/21, indicated the nursing/CNA (Certified Nurse Aid) would put on a right-hand splint upon rising in the morning and to check the skin frequently for signs of decreased skin integrity. A physician's order, dated 9/1/21, indicated the nursing/CNA would take off the right-hand splint before the resident went to bed in the p.m. During an observation, with CNA 8 on 8/15/21 at 2:50 p.m., the resident did not have a splint on her right hand. CNA 8 located the splint in her nightstand by the bedside and indicated she did not know why the resident was not wearing her splint. During an interview, on 8/15/23 at 2:59 p.m., the LPN indicated she did not usually work the unit and she did not know about the splint for Resident 14. During an interview, on 8/15/23 at 3:01 p.m., the Unit Manager (UM) indicated the staff were signing on the Medication Administration Record (MAR) and Treatment Administration Record (TAR), the splint had been applied daily.2. The record for Resident 57 was reviewed on 08/11/23 at 9:20 a.m. Diagnoses included, but were not		identified and what corrective action(s) will be taken. An audit of all residents will identify those with physician orders or the need for new orders for assistive devices (Exhibit J) 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All resident orders will be updated to include orders for necessary assistive devices. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. An audit will be conducted five days a week for three months, three days a week for two months, and one day a week for one month to ensure the accuracy of care related to assistive devices (Exhibit K)	

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	limited to, cerebral palsy, and left-hand contracture. A physician order, dated 7/7/23, indicated a palm protector was to be in the left hand donned upon bed and doffed upon rising. An electronic Medication Administration Record (MAR), dated July 2023, indicated there was no documentation by the staff for the placement or removal of the palm protector. An electronic MAR, dated August 2023, indicated there was no documentation by the staff for the placement or removal of the palm protector. During an interview, on 08/15/23 at 3: 39 p.m., Nurse 5 indicated she had not seen a palm protector for the resident. A current policy, titled "Use of Assistive Devices," not dated and received from the Director of Nursing on 8/15/23 at 4:18 p.m., indicated "...the use of devices would be based on the resident's comprehensive assessment, in accordance with the resident's plan of care...the facility will provide assistive devices for resident's who need them...nursing, dietary, social services, and therapy department will work together to ensure availability of devices, such as for ordering and/or replacement...facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices...this may include education or therapy sessions for training on the use of the device, set up assistance supervision or physical assistance needed...direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices...training will also include when to refer to other departments for changes in			

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	condition or problems with device...a nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device...refusals of use, or problems with device will be documented in the medical record...modifications to the plan of care will be made as needed.... " 3.1-42(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure a resident's oxygen was set at the physician ordered liters per minute (LPM) and the oxygen tanks were stored safely for 1 of 1 resident reviewed for oxygen. (Resident 15) Finding includes: During an observation, on 8/9/23 at 1:34 p.m., Resident 15's oxygen (02) was set at 4 LPM. The resident indicated the 02 should be at 3 LPM. During an observation and interview, on 8/9/23 at 1:47 p.m., the resident's 02 was still at 4 LPM and RN 6 indicated the resident's oxygen was supposed to be set at 3 LPM.	F 0695	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 15's oxygen was set at 4LPM and the physician order was for oxygen at 3LPM. The resident's oxygen setting was changed to 3LP. The canisters were removed from resident 15's room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	09/11/2023

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	The record for Resident 15 was reviewed on 8/11/23 at 11:23 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia (low 02 content in the blood), chronic respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream), congestive heart failure, and anxiety disorder. A physician's order, dated 7/19/23, indicated 02 at 3 LPM by nasal cannula. A care plan, dated 12/15/21 and last revised on 4/24/23, indicated the resident was at risk for respiratory distress related to chronic respiratory failure with hypoxia/hypercapania, fluid overload, and sleep apnea. The interventions included, but were not limited to, administer oxygen as ordered. During an observation with Executive Director (ED), on 8/16/23 at 2:55 p.m., the resident's 02 was set at 3.5 LPM. There were five 02 canisters sitting on the floor in the corner of the room close to the doorway without any holder. The ED indicated the 02 canisters should be in a holder and some of the canisters were full and some were empty. A current policy, titled "Oxygen Administration," not dated and received from the ADON (Assistant Director of Nursing) on 8/15/23 at 11:34 a.m., indicated, "...Oxygen is administered to residents who need it, consistent with professional standards or practice, the comprehensive person-centered care plans, and the resident's goals and preferences...'Oxygen therapy' is the administration of oxygen at concentrations greater than that in ambient air...with the intent of treating or preventing the symptoms and manifestations of hypoxia...'Hypoxia' means decreased perfusion of oxygen to the tissues...Oxygen is administered		action(s) will be taken. All residents who utilize oxygen therapy have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All residents with oxygen orders will be reviewed by the DNS or designee for administration accuracy. All staff will be inserviced on the “Oxygen Safety” policy (Exhibit E). An audit will be conducted weekly by the DNS or designee to ensure the safe storage of oxygen canisters (Exhibit F). Clinical staff will be inserviced on the “Oxygen Administration” policy 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Residents with oxygen orders will be audited by the DNS or designee; an audit will be conducted five days a week for three months, three days a week	

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	under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control...." A current policy, titled "Oxygen Safety," not dated and received from the ADON on 8/16/23 at 3:35 p.m., indicated "...It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and the oxygen equipment...Safety is the responsibility of all staff, residents, visitors, and the general public...Staff, residents, and families will be educated on oxygen safety precautions in accordance with their roles and responsibilities related to the use and storage of oxygen...Oxygen Storage...Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. Empty cylinders shall be segregated from full cylinders. Empty cylinders will be marked to avoid confusion...Cylinders will be properly chained or supported in racks or other fastenings [i.e. sturdy portable carts, approved stands] to secure all cylinders from falling, whether connected, unconnected, full, or empty...When small-size [A, B, D, or E] cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders...Handling Oxygen Cylinders...Protect cylinders from damage by not storing in locations where heavy objects may strike them or fall on them, or where they can be tipped over by foot traffic or door movement...." 3.1-47(a)(6)		for two months, and one day a week for one month to ensure the accuracy of care related to assistive devices (Exhibit G)	

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F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to ensure there was enough staff to address concerns identified by the resident council group for 7 of 7 resident council meetings reviewed, to provide incontinence care as identified by grievance concerns for 5 of 5 grievances reviewed, and to provide toileting needs for 2 of 2 residents reviewed for bowel and bladder. (Resident C and E)	F 0725	ol class="NumberListStyle1 SCXW48831055 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished for those residents	09/11/2023

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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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	Findings include: 1. There were no documented responses to concerns from January 2023 to July 2023 from the resident council group meetings. During the resident council meetings, from January 2023 through July 2023, the resident council indicated there were concerns about call lights taking a long time, medication pass taking too long, showers not consistently done, the rooms needed cleaned and soap and toilet paper needed refilled. No follow up was done for their concerns. During the resident council interview, on 8/16/23 at 2:00 p.m., the resident council group indicated there was a lack of communication with residents and staff. The residents did not feel they could communicate with providers about their care. 2a. A grievance, dated 11/14/22, indicated Resident K would turn on his call light and the staff would say they would be right back and then would not return for hours. The staff indicated they could not see the call light well due to the facility windows. The grievance was confirmed, and the staff were educated. b. A grievance, dated 2/6/23, filled out by [name of hospice nurse], indicated Resident K was found soaked in a pool of urine and had saturated bed sheets and bed pads. The grievance was confirmed, and staff were educated on the importance of 2-hour resident checks. c. A grievance, dated 2/21/23, indicated Resident H was changed overnight although was left in soiled, wet clothing. There was dried urine underneath the resident and all over the chair and		found to have been affected by the deficient practice. Resident K discharged from the facility on 05/18/2023. Resident G discharged from the facility on 04/29/2023. Resident H expired on 07/05/2023. p paraid="346211063" paraeid="{ad656ad7-60a4-4a15-a263-8718b3d8b8d4}{239}" >The staff member involved in the allegation made by resident C was permanently removed from caring for the resident. Call light monitoring for resident C will be implemented in order to monitor wait times. A care plan with resident E will be conducted to address all outstanding concerns of the resident. Resident J was changed according to the grievance. Resident J will be interviewed as to her satisfaction with being assisted with changing and her concerns addressed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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	incontinence pad. The grievance was confirmed, and the staff was educated on the importance of checking clothing after incontinence episodes. d. A grievance, dated 2/21/23, indicated Resident G was found saturated in urine due to no staff went in during the night to check on the resident. The grievance was confirmed, and staff education was provided. The facility also called in agency staff to help with staffing needs. e. A grievance, dated 4/20/23, filled out by [name of hospice nurse] indicated Resident J was trying to get changed since before breakfast due to wetting her pant. She was changed during lunch around 11:30 a.m. The grievance was not confirmed since the resident was checked by staff one day later and was found to be dry. The grievance did not have an interview from the hospice staff who indicated the resident was not changed. 3a. During an interview, on 8/10/23 at 2:44 p.m., Resident C indicated during the second shift her call light was on. CNA 3 came to the door and told her she was just changed 10 minutes ago, and the CNA would come back in 2 hours to change her. The resident told the CNA she had a bowel movement and she needed to be changed. CNA 3 turned off the call light and told the resident she only had to change her every two hours and CNA 3 left the room. The record for Resident C was reviewed on 8/14/23 at 3:45 p.m. Diagnoses included, but were not limited to, clostridium difficile colitis (inflammation of the colon caused by bacteria which could cause diarrhea), diabetes mellitus, and fracture of the upper end of the left humerus		action(s) will be taken. All residents have the potential to be affected. ol class="NumberListStyle1 SCXW48831055 BCX8" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Call light monitoring will be done using a call light audit tool at random on a daily basis and reviewed in the daily stand up meeting to ensure call light response times are within acceptable limits based on the needs of the resident and their plan of care (Exhibit P) How the corrective action(s) wilal be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the call light audits will be reviewed in the QAA meeting for 6 months.	

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	(the largest bone of the upper arm). A care plan, dated as revised on 8/1/23, indicated the resident had diarrhea, loose stools and was positive for c-diff. The goal included to assist with peri care as needed and to assist with incontinent care as needed. During an interview, on 8/16/23, the Director of Nursing (DON) indicated the CNA may have been frustrated due to the amount of care the resident required. 3b. During an interview, on 8/9/23, a CNA indicated Resident E would lay in feces for a long time before staff would assist in cleaning him and the resident agreed. The record for Resident E was reviewed on 8/10/23 at 4:50 p.m. Diagnoses included, but were not limited to, cervical spina bifida with hydrocephalus, paraplegia, peripheral vascular disease, and chronic pain. During an interview, on 8/15/23 at 11:17 a.m., CNA 11 indicated there was not enough staff to get all the work done. The facility had low staffing. During an interview, on 8/15/23 at 11:19 a.m., CNA 12 indicated the facility usually had only one CNA in the hall and it took two CNAs to keep up with the work. During an interview, on 8/15/23 at 11:22 a.m., the Unit Manager indicated the unit should have 5 CNAs and currently only had 3 CNAs. During an interview, on 8/16/23 at 3:24 p.m., the Director of Nursing indicated there had been staffing challenges on the second shift. She			

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	would ask staff to stay over if there was not enough staff. The third shift had problems of call lights not being answered and she had worked on the third shift to monitor the call lights. The CNAs had been taking extra breaks and these were the staff complaining about not being able to get their work done. A current policy, titled "Staffing," dated as revised October 2017 and received from the Unit Manager on 8/16/23 at 6:03 p.m., indicated "...Our facility provides sufficient numbers of staff with the skill and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment...Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care...." 3.1-17(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.			

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	§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure posted staffing data had the actual worked hours per shift for 3 of 3 months reviewed for staffing. (6/4/23 through 8/9/23). Findings include: During an observation, on 8/9/23 at 12:00 p.m., the census and staffing hours form posted at the main entrance, dated 6/4/23, indicated there were 94 residents, 2 RN's (Registered Nurses), 1 LPN (Licensed Practical Nurse), and 9 CNAs (Certified Nursing Assistant)/QMAs (Qualified Medication Assistant) with a total of 91.5 hours worked for the day shift. The evening shift had 1 RN, 2.5 LPNs, and 9 CNAs/QMAs for total of 64 hours worked. The night shift had 1 RN, 2 LPNs and 5 CNAs/QMAs for a total of 64 hours worked.	F 0732	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The correct nursing hours were posted (Exhibit O) 2. 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. All alert and oriented residents who wish to know the staffing hours are potentially affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A new scheduler has been	09/11/2023

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	The staffing hours and census form did not provide actual worked hours and the numbers indicated half staff members (2.5 LPNs) posted. During an interview, on 8/10/23 at 11:11 a.m., the Clinical Support Nurse indicated the staffing posted was from 6/4/23 and he did not know why the staffing had not been updated. During an observation, on 8/11/23, the census and staffing hours form, dated 8/11/23, did not have the actual worked hours posted. During an interview, on 8/16/23 at 4:45 p.m., the Director of Nursing indicated the facility did not have a policy for posted nurse staffing.		hired and trained in the appropriate posting of staffing hours. The DNS or designee will review the posted hours for accuracy and ensure they are current and review in the daily stand-up meeting 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The posted hours audit will be reviewed in the QAA meeting for 6 months.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;			

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	§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview and record review, the facility failed to ensure a resident received routine oral care and follow up dental visits for 1 of 1 resident reviewed for dental services. (Resident 14) Finding includes: During an observation, on 8/9/23 at 1:10 p.m., Resident 14 had very blackened bottom teeth, missing teeth and partial tooth pieces. There was a very foul odor noted when the resident was smiling and attempting to speak. During an interview, on 8/10/23 at 4:42 p.m., the resident's family member indicated the facility did	F 0791	ol class="NumberListStyle1 SCXW194565232 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Necessary supplies will be provided for resident 14 and daily assistance for dental will hygiene will be provided by staff and	09/11/2023

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	not help the resident with her teeth and did not even give her a toothbrush at bedtime. The resident's teeth were really bad and she needed dental work. The place the facility sent her to could not do anything. The record for Resident 14 was reviewed on 8/11/23 at 3:02 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis) and hemiparesis (weakness) following unspecified cerebrovascular disease affecting the right dominant side, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and vascular dementia. A physician's order, dated 8/24/21, indicated the resident could be seen by the podiatrist, dentist, and optometrist. A care plan, dated 8/24/21, indicated the resident needed assistance with activities of daily living and had impaired mobility, a history of a cerebrovascular accident with right side hemiplegia, limited range of motion to the right upper extremity, and impaired cognition. The interventions included, but were not limited to, staff to assist/encourage oral care twice daily and as needed. A care plan, dated 8/24/21, indicated the resident was at a risk for dental/mouth problems related to having her natural teeth with many missing teeth and a history of periodontal disease. The interventions included, but were not limited to, coordinate arrangement for dental care, transportation as needed, and to observe for signs of dental problems and decay. A dental note, dated 1/20/2020, indicated the resident had 16 missing teeth, poor periodontal		documented through the POC in the electronic record. 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. A care plan will be scheduled with the resident’s family to discuss a follow-up dental appointment and ensure a date, time and provider and transportation are coordinated with the family, staff and resident. p paraid="738972359" paraeid="{b8b0af78-ebd3-4d5c-9669-82730b2cddd3}{251}" > What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. ·A 100% audit of all residents will be done to ascertain those requiring dental services and dental visits will be scheduled for those residents who are requiring an appointment. All identified residents will be reviewed in the weekly standup to	

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	health and periodontitis with swollen gums. The resident needed dental cleanings twice a year. A referral to [name of dental facility] was completed on 2/3/21. There was no visit note from [name of dental facility] in the resident record. A clinical note, dated 3/1/23, and faxed to the facility on 8/15/23, indicated the resident had an oral examination and limited X-rays taken. The resident had severe generalized calculus (a build up on the teeth which could lead to cavities, swollen gums and other oral health conditions) and multiple fractured teeth. The resident needed intervention by multiple specialists and a was referred to IU health department for the needed care. There was no documentation in the resident's record to show any follow up appointments for her dental issues had been scheduled. During an observation with CNA 8, on 8/15/23 at 2:50 p.m., there was no toothbrush located in the resident's room. CNA 8 searched the bedside table, both dressers, and the bathroom. During an interview, on 8/16/21 at 3:11 p.m., the Social Services Assistant indicated the resident's son was working with IU dentistry school to set up a dental appointment. This was discussed during the July care plan meeting. She did not know why an appointment had not been set up sooner since the resident was last seen by a dentist in 2/2023 and the follow up appointment was recommended then. The facility had not provided documentation of		audit upcoming dental visits to ensure appointments are coordinated in a timely manner. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the weekly audit will be reviewed in the QAA meeting for 6 months.	

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	the July care plan meeting about the son setting up a dental appointment by the time of exit. A current policy, titled "Dental Services and Missing Dentures," dated July 2020 and received from the Director of Nursing (DON) on 8/15/23 at 4:18 p.m., indicated "...The facility obtains needed dental services, including routine and emergency dental services; assists in providing these services and makes prompt referrals for dental services as needed...The facility will obtain contracted outside dental services to meet the routine and emergency dental needs of each resident...The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under Medicaid...The facility will assist in scheduling and transporting residents to dental appointments as needed. Efforts will be taken to minimize out of pocket costs to the resident or representative as applicable by attempting to utilize low cost transportation...." 3.1-24(a)(1) 3.1-24(b)			
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. Based on observation and interview, the facility failed to ensure rooms were free from urine odors, free from dirty clothes on the floor and bedside tables, free from cardboard boxes on the floor and stacked on a plastic bin, personal belongings scattered in rooms, dirty clothes and a pillow on the floor for 6 of 6 rooms and failed to ensure flooring was replaced for 1 of 2 units reviewed for	F 0921	ol class="NumberListStyle1 SCXW126653113 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;"	09/11/2023

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	environment. (Rooms 105, 106, 108A, 110B, 112, 214, and the Cedarwood Unit) Findings include: During room observations, starting on 08/10/23 at 10:41 a.m., the following were observed: a. Room 105 had a slight urine odor. b. Room 106 had clothes all over the floor and the side of room, bed sheets were rolled up and a food tray was still sitting on the bedside table. c. Room 108A had a lot of clutter in the room, items were on the floor and chairs. The clothing and other personal belongings were unorganized. Two large cardboard boxes were stacked on top of each other, and another large cardboard box was stacked on top of a plastic bin. d. Room 110B had clothing in bags on the floor next to bed, multiple personal belongings were scattered all over the room. e. Room 112 had piles of clothing sitting on top of the walker in room, unable to tell if the clothing was clean or dirty and a pillow on the floor. f. Room 214 had one dirty hospital gown rolled up on the bedside table and one dirty gown rolled up on the chair. g. The hallway floor on the Cedarwood Unit was missing a large amount of flooring in front of the nurse's station. During an interview, on 8/9/23 at 1:28 p.m., RN 6 indicated the urine smell was from the resident who was incontinent and refused care. During an interview, on 8/16/23 at 2:58 p.m., the Executive Director (ED) indicated the boxes could be from unpacking. The clothing items in open bags and on the recliner were most likely dirty clothes.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Room 105 was immediately cleaned, the linens washed and the mattress cleaned and disinfected. The resident was provided care. The clothes in room 106 were removed, washed and stored folded or hung in the closet of the room. The food tray was immediately removed and returned to the kitchen. Room 108 A was reorganized. The clothing was removed and taken to laundry and returned to the room in an organized state. The card board boxes were removed from the floor and the contents sorted and placed in a dresser in the room. The clothing in room 110 B was removed, taken to laundry and returned to the room in an organized state. The clothing in room 112 was removed, taken to laundry and replaced to the room in an organized state. The hospital gown in room 214 was removed, taken to laundry and replaced to the room in an organized state. The hallway floor on the Cedarwood unit was covered with a similar laminated vinyl tile product. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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	During a facility tour, on 8/10/23 at 10:52 a.m., with the ED and Director of Nursing (DON), the ED indicated Room 105 had a slight urine odor and indicated the environmental staff must have measures for the strong urine odor coming from the room. The ED looked in Room 106 and asked the resident about the laundry. The resident did not know why the clothes were all over floor. The ED indicated the damage for the flooring on the Cedarwood Unit was from a water heater hose. They were going to try and replace the missing section and the whole flooring. The facility had submitted a proposal for repair. The water damage came from the janitor's water heater hose and not the shower. The water damage happened six weeks ago. During a facility tour, starting on 08/16/23 at 2:33 p.m., with the Executive Director and Maintenance Director, the ED stated they were trying to get a capital order quote for the flooring on the Cedarwood Unit. There were no purchase orders for two months since the damage flooring was removed. Room 105 was on a deep clean schedule; the mattress was covered by a membrane but odor might be coming from the curtains. A current policy, titled "Department (Environmental Services) - Laundry and Linen," dated as revised on 1/2014 and received from the DON on 8/15/23 at 4:19 p.m., indicated "...Consider all soiled linen to be potentially infectious and handle with standard precautions...All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture...Handle soiled linen as little as possible to prevent agitation...." A current policy, titled "Homelike Environment,"		action(s) will be taken. ·All rooms will be audited for clutter, odor, accumulation of unwashed laundry. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Magic rounds will be conducted daily by the IDT team. The management team was educated on the expectations of daily room rounds and what is acceptable clutter and what is not. Rounds of rooms on each hallway will be made and results reviewed in the daily stand-up meeting. Items needing correction will be assigned to the correct department and reviewed the next business day for completion (Exhibit Q) ol class="NumberListStyle1 SCXW126653113 BCX8" role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" How the corrective action(s) will be monitored to ensure the deficient	

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	08/16/2023

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

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	dated as revised on 5/2017 and received from the DON on 8/15/23 at 4:18 p.m., indicated "...The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include; clean, sanitary and orderly environment...Pleasant, neutral scents...." 3.1-19(f)(5) 3.1-19(g)(1) 3.1-19(g)(2)		practice will not recur, i.e., what quality assurance program will be put into place. A trending of the room rounds will be reviewed in the QAA meeting for 6 months to ensure consistent correction of findings.	