STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 00 B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00387762. Complaint IN00387762 - Substantiated. Federal/state deficiencies related to the allegations are cited at F641, F656, F842 and F886. Survey dates: August 26 and 29, 2022 Facility number: 000477 Provider number: 155570 AIM number: 100290860 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 6 Medicaid: 26 Other: 5 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on September 2, 2022	F 0000	We respectfully request that this plan of correction be considered for a desk review in lieu of a post survey revisit. Thank you.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the admission Minimum Data Set (MDS) assessment was accurately completed using the information from the Nursing Admission	F 0641	p paraid="837365878" paraeid="{ca4cf87e-b933-4cae-9a48-276edb70acd3}{184}" >What corrective action will be	09/16/2022

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

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	Evaluation for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Findings include: The clinical record for Resident F was reviewed on 8-29-22 at 12:28 p.m. His diagnoses included, but were not limited to, unspecified severe protein calorie malnutrition, dysphagia, type 2 diabetes, hypertension, hyperlipidemia, heart disease, depression, urinary retention, anemia and gastrostomy status (feeding tube). His admission MDS, dated 8-3-22, failed to identify any pressure ulcers or other skin issues of the resident. His "Nursing Admission/Readmission Evaluation," dated 7-27-22, indicated he was admitted to the facility on the same date with a stage II pressure ulcer to his coccyx and a stage I pressure areas to his inner right and left buttocks. Review of a nursing progress note, dated 7-27-22 at 8:45 p.m., indicated Resident F had been admitted to the facility and had "Stage II open area on coccyx. Superficial open areas inner right and left buttocks." Wound care team notes, dated 7-28-22 identified Resident F's pressure ulcer. Additional documentation from the wound care team on 8-1-22, 8-8-22 and 8-22-22, indicated he was seen for assessment, evaluation and treatment of a stage II pressure ulcer pressure ulcer. The Executive Director (ED) and she indicated she was unaware of the lack of accuracy of the document. On 8-29-22 at 2:40 p.m., The ED indicated the facility does not have a particular policy regarding MDS assessment, but follows the Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual. The RAI indicates steps for assessment of the resident for		accomplished for those residents found to have been affected by the deficient practice; Resident F no longer has a wound. Any future changes MDS assessment and care plans will be updated as needed. p paraid="590162304" paraeid="{ca4cf87e-b933-4cae-9a48-276edb70acd3}{215}" > How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions have been taken; All residents residing in the facility that have a wound have been audited to ensure MDS assessment accuracy and care plan is in place and is being monitored. p paraid="885078942" paraeid="{ca4cf87e-b933-4cae-9a48-276edb70acd3}{250}" >What measures will be put into place or	

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	pressure ulcers include, but are not limited to, a review of the medical record, including nurses' notes. Coding for pressure ulcers includes, but is not limited to, identifying all skin areas that are identified as a stage I or greater. This Federal tag relates to Complaint IN00387762. 3.1-31(a) 3.1-31(c)(2) 3.1-31(c)(4)		what systemic changes will be made to ensure the deficient practice does not recur; Current wound care plans and all MDS assessments have been audited to ensure accuracy. Admissions reviews to be done on all new admissions to ensure care plans MDS assessment are in place and accurate. · MDS coordinator and DNS to be in regard to care plan monitoring and MDS assessment accuracy. p paraid="1442850618" paraeid="{7ed8c2e2-bef5-47f3-a9c1-6cfa4357134e}{51}" >How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; QAPI audit tool “care plan” and Admission MDS assessment will be completed by DNS/designee weekly x4 and then monthly x6 thereafter and findings will be brought to monthly QAPI for review	

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			and any deficiencies will be corrected.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			

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	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview the facility failed to develop a plan of care of a resident with a stage 2 pressure area to the left heel for 1 of 3 residents reviewed for skin impairments. (Resident G). Findings include: The clinical record for Resident G was reviewed on 8/26/2022 at 3:06 p.m. The medical diagnoses included, but were not limited to, muscle weakness and age-related debility. A Quarterly Minimum Data Set Assessment dated 7/13/2022, indicated Resident G had a stage 3 pressure area. No skin impairment care plan was on the clinical record. A nursing pressure wound evaluation dated 7/28/2022, indicated that Resident G had a stage 2 pressure area to the left heel with a date acquired of 5/26/2022. An interview with the Executive Director on 8/29/2022 at 12:52 p.m. indicated she believed there had been a paper care plan for Resident G but they are unable to find it due to converting to	F 0656	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** · **Resident G no longer has a wound. Any future changes care plans will be updated as needed.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions have been taken;** · **All residents residing in the facility that have a wound have been audited to ensure a care plan is in place and is being monitored.** **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur;** · **Current wound care plans have been audited to ensure accuracy. Admissions reviews to be done on all new**	09/16/2022

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	electronic records. A policy entitled, "Care Plans, Comprehensive Person-Centered", was provided by the Executive Director on 8/29/3033 at 2:39 p.m. The policy indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...". This Federal tag related to complaint IN00387762. 3.1-35(b)(1)		**admissions to ensure care plans are in place and accurate.** **· MDS coordinator and DNS to be inserviced in regard to care plan monitoring and accuracy.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;** **· QAPI audit tool "care plan" will be completed by DNS/designee weekly x4 and then monthly x6 thereafter and findings will be brought to monthly QAPI for review and any deficiencies will be corrected.**	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-			

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	(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must			

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	contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure documentation reflected a change of condition with appropriate notifications, vital signs and care orders were only documented for residents when they were physically present in the facility and transmission-based precautions (TBP), including physician orders, utilized for residents were documented, for 4 of 4 residents reviewed for accuracy of documentation. (Residents B, D, E and F) Findings include: 1. The clinical record of Resident B was reviewed on 8-26-22 at 11:15 a.m. His diagnoses included, but were not limited to prothrombin gene mutation (or genetic blood clotting problems), right knee osteoarthritis, lung cancer, COPD (chronic obstructive pulmonary disease or lung problems) and spontaneous ecchymosis (bloody nose). A review of Resident B's progress notes indicated the Nurse Practitioner had written a notation, dated as a late entry on 6-23-22 at 9:40 p.m., regarding a visit she had conducted with Resident B due to abnormal labs. It indicated she ordered the resident to be sent to the local emergency	F 0842	p paraid="1509221919" paraeid="{72e35753-2a2e-4a05-aca1-21e44b977753}{209}" >What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident B no longer resides in the facility. Resident F had no negative outcomes due to the incorrect charting. Resident D had no negative outcomes due to the alleged deficient practice. Resident E no longer resides in the facility. ·In-service completed on change of condition (SBAR) completion for each resident change in condition. How other residents having the potential to be affected by the	09/16/2022

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	room for further evaluation and treatment. There were no other progress notes to address how the Nurse Practitioner had become aware of the abnormal lab values or a change in the condition of the resident. Resident B was sent out to the hospital on the evening of 6-23-22 for further evaluation and treatment, as ordered. He did not return to the facility. A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the month of June, 2022 was conducted. A review of Resident B's vital signs indicated his Covid-19 monitoring for signs and symptoms, including his temperature, respirations, and oxygen saturation were documented for the evening shift on 6-26-22, on night shift on 6-23-22, 6-24-22 and 6-25-22. His vital signs of blood pressure, temperature, pulse, oxygen saturation and pain level were documented on the evening shift on 6-26-22 and the night shift on 6-23-22, 6-24-22 and 6-25-22. His oxygen saturation levels, related to elevating the head of the bed to minimize shortness of breath when lying flat indicated this value was obtained on the evening shift on 6-26-22 and on the night shift on 6-23-22, 6-24-22 and 6-25-22. The use of a pressure reduction cushion (location not specified) was documented as completed on 6-26-22 evening shift and on the night shift of 6-23-22, 6-24-22 and 6-25-22. 2. The clinical record for Resident F was reviewed on 8-29-22 at 12:28 p.m. His diagnoses included, but were not limited to, unspecified severe protein calorie malnutrition, dysphagia, type 2 diabetes, hypertension, hyperlipidemia, heart disease, depression, urinary retention, anemia and gastrostomy status (feeding tube). A review of the progress notes indicated he was sent out to		same deficient practice will be identified and what corrective actions have been taken; ul class="BulletListStyle1 SCXW163545097 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" that performed charting on resident B is no longer employed with the facility. In addition, residents that are discharged will have all orders discontinued upon discharge. that performed charting on Resident F no longer works at the facility. Education provided to all nursing staff on completing change in condition (SBAR) for any resident change in condition including hospital transfers Resident D - Nursing staff will be prior to 9/16/2022 on new admission covid procedures. Admission review will be completed for new admitted residents to ensure physician orders for transmission-based precautions if needed. Resident E - Nursing staff will be prior to 9/16/2022 on new admission covid procedures. Admission review will be	

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	the hospital on 8-14-22 on the evening shift and returned to the facility on 8-18-22 on the evening shift. A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the month of August, 2022 was conducted. It indicated on the night shift of 8-15-22, he was documented to have received the following care: -received the house barrier cream to his buttocks, coccyx and peri-area with each incontinent episode. -received foley catheter care each shift and as needed. -received menthol-zinc oxide cream to the buttocks each shift for prevention. -not to use his left arm for blood pressure readings due to contracture. -use of a pressure reduction cushion to the wheelchair every shift. -use of a pressure reduction mattress every shift. 3. The clinical record for Resident D was reviewed on 8//26/2022 at 1:09 p.m. the medical diagnoses included, but were not limited to, glaucoma and behaviors disturbances. Resident D was admitted on 8/15/2022, was over 50 years of age, and had received the primary series Covid-19 vaccination with one booster. Resident D had no physician orders for transmission-based precautions. Nursing documentation for Resident D on 8/16/2022, 8/17/2022, and 8/18/2022 indicated that Resident D was not on contact or droplet transmission-based precautions. 4. The clinical record for Resident E was reviewed		completed for new admitted residents to ensure physician orders for transmission-based precautions if needed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur; ul class="BulletListStyle1 SCXW163545097 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Nursing staff will be prior to 9/16/2022 on new admission covid procedures. Admission review will be completed for new admitted residents to ensure physician orders for transmission-based precautions if needed. Nursing staff will also be prior to 9/16/2022 on discontinuing orders upon resident's discharge. Education on resident change in condition (SBAR) with each change of condition and hospital transfer How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; QAPI audit tool "EMAR	

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	on 8/26/2022 at 1:14 p.m. The medical diagnoses included, but were not limited to, chronic obstructive pulmonary disease and anxiety. Resident E was admitted on 7/29/2022, was over 50 years of age, and had received the primary series Covid-19 vaccination with one booster. Resident E had no physician orders for transmission-based precautions. Nursing documentation for Resident E reflected that on 7/30/2022 and 8/1/2022 that Resident E was not on contact or droplet transmission-based precautions. An interview with Resident E on 8/26/2022 at 2:50 p.m. indicated that the first week she was here, the staff used special gowns, masks, and visors when they came into her room. An interview with the DON on 8/26/2022 at 2:05 p.m. indicated that there should be orders for the "yellow zone", or area for contact/droplet transmission-based precautions for residents at risk from exposure or recent admission. She indicated that all residents over 50 year of age would be placed in the yellow zone unless they had received a primary series and 2 boosters. If they are under 50, then they would only need the primary series and one booster. She verified that Resident D and Resident E were on transmission based precautions after admission. A policy entitled, "Covid-19 Admission/Re-admission Guidance", as provided by the Executive Director on 8/29/2922 at 1:53 p.m. The policy indicated, " ...All new admission that are not up-to-date and do not test positive for COVID-19 will be placed in transmission-based		documentation for discharged residents" and QAPI audit tool "new admissions" Covid-19 admission procedures and auditing tool for change in condition (SBAR) will be completed by DNS/designee weekly x4 and then monthly x6 thereafter and findings will be brought to monthly QAPI for review and any deficiencies will be corrected.	

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	precautions (yellow zone) for 10 days ..." A policy entitled, "Charting and Documentation", was provided by the Executive Director on 8/29/3033 at 2:39 p.m. The policy indicated, "All services provided to the resident, progress toward the care plan, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical records ...Documentation in the medical record will be objective (not opinionated to speculative), complete, and accurate ..." This Federal tag related to complaint IN00387762. 3.1-50(a)(1) 3.1-50(a)(2)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 00 B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

(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
	specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.			

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	§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on interview and record review, the facility failed to complete admission Covid-19 testing immediately (Resident C) and repeated at 5-7 days (Resident E) for 2 of 5 residents reviewed for Covid-19 admission testing. Findings include: 1. The clinical record for Resident C was reviewed on 8/26/2022 at 12:58 p.m. Medical diagnosis included, but not, Alzheimer's disease. Resident C was admitted on 7/27/2022. Resident C had Covid-19 point of care antigen test completed on 7/29/2022 and 8/2/2022. 2. The clinical record for Resident E was reviewed on 8/26/2022 at 1:14 p.m. The medical diagnoses included, but were not limited to, chronic obstructive pulmonary disease and anxiety. Resident E was admitted on 7/29/2022. Resident C had Covid-19 point of care antigen test completed on 7/29/2022 and 8/2/2022 (Day 4). An interview with Director of Nursing on 8/26/2022 at 1:05 p.m. indicated she was not sure why the testing was not completed at admission for Resident C and was completed on Day 4 for Resident E. A policy entitled, "COVID-19 Testing	F 0886	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **· Resident C had no negative outcome from the alleged deficient practice. Resident E no longer resides in the facility.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions have been taken;** **· Covid test audits will be done to ensure new admission covid testing was done timely.** **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur;** **· Nursing staff will be inserviced prior to 9/16/2022 on new admission covid testing procedures. Admission review will be completed for new admission residents to ensure covid testing was completed.**	09/16/2022

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	Requirements", was provided by the Director of Nursing on 8/26/2022 at 12:40 p.m. The policy indicated, " ...In keeping with current CDC [Center for Disease Control and Prevention] recommendations, newly admitted residents and residents who have left the facility for > 24 hours regardless of vaccinations status, should have a series of two viral tests for COVID-19 infection: immediately and, if negative, again in 5-7 days after admission/return". This Federal tag related to complaint IN00387762.		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;** **· QAPI audit tool "admission covid testing" will be completed by DNS/designee weekly x4 and then monthly x6 thereafter and findings will be brought to monthly QAPI for review and any deficiencies will be corrected.**	