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	07/21/2023

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 IN00412708. Complaint IN00412708. Federal/state deficiency related to the allegations is cited at F684. Survey dates: July 20 and 21, 2023 Facility number: 000477 Provider number: 155570 AIM number: 100290860 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 3 Medicaid: 24 Other: 3 Total: 30 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2023	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 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			

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

Katlyn Collins | HFA | 08/10/2023

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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	comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure all falls and associated follow-up related to each fall, were documented in the clinical record, a thorough post-fall investigation was conducted, including, but were not limited to, verification of following the current care plan interventions were implemented for 2 of 3 residents reviewed for falls. (Resident B and D) Findings include: 1. The clinical record of Resident B was reviewed on 7-20-23 at 12:04 p.m. Her diagnoses included, but were not limited to, Huntington's disease and dementia. Her most recent Minimum Data Set (MDS) assessment, dated 6-19-23, indicated she was non-verbal, had short-term and long-term memory problems and was severely cognitively impaired; was non-ambulatory and used a wheelchair for mobility, she required extensive assistance of two or more persons to totally dependent for all activities of daily living, such as eating, bathing, turning and repositioning, toileting and mobility. A fall risk assessment, dated 4-25-23, identified this resident as a moderate fall risk on 4-25-23. An updated fall risk assessment, dated 7-3-23, post-fall, identified this resident as a high fall risk. Resident B's clinical record indicated on 7-2-23 at 11:30 a.m., "Writer was called by staff that patient is on the floor. Found patient lying on her left side close to bed. [sic] upon assessment, hematoma [bruise] noted on left forehead and scratch on left knee. Alert and able to move all extremities. Ice pack applied on forehead, first aid performed on left knee. prn [as needed] Tylenol given. On call NP [nurse practitioner], daughter and DON	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was assessed, and all appropriate fall interventions are in place. Resident D was assessed with no negative outcome. **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 that reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was completed for all residents with fall intervention care plans on 8/4/2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff was educated on fall follow up, post fall investigations, and fall interventions on 8/4/2023 by the Executive Director/Designee. The IDT will round daily, 5 days per week, to ensure proper fall precautions are in place. Any deficient practice will be reported to the Executive Director for correction.	08/04/2023

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	[Director of Nursing] made aware. Neuro check [neurological exam] initiated." A review of the fall by the Interdisciplinary Team was conducted the next day, which identified "fall mat not down and bed was not in the lowest position," as a contributing factor to the unwitnessed fall. A facility document, identified as an "incident report," and specified to be, "Privileged and Confidential - not a part of the Medical Record," was provided by the facility as a part of the facility's investigation for Resident B. It indicated the unwitnessed fall occurred on 7-2-23 at 9:30 a.m. It indicated Resident B was found by RN 7, after notification by an unspecified CNA, lying on the floor on her left side and close to her bed. It indicated Resident B was assessed to have a hematoma on her left forehead and a scratch to her left knee, but was alert and able to move her extremities and notifications were made to her daughter, the nurse practitioner on call and the DON. It indicated neurochecks were initiated and "no injuries post investigation." Predisposing factors identified were confusion, impaired memory and incontinence. A review of the post-fall neurochecks for Resident B indicated she was neurologically stable for 72 hours post-fall. In an interview with a family member on 7-21-23 at 11:01 a.m., she indicated a sibling had been notified by the facility of Resident B's fall on the morning of 7-2-23. She specified it had been a long-term intervention that her mom's bed was to be left in the lowest position and with the floor mat in place whenever someone is not directly working with her. She added in the fall notification, the facility stated Resident B had been found on the floor, with no floor mat in place		**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;** QAPI tool for Falls will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	and the bed was not in the lowest position. She indicated the facility had not provided clear information on how this happened or who was responsible. She elaborated she arrived after the fall and was with her mother from about 10:00 a.m. to 2:00 p.m., and she had taken multiple pictures of her mother's facial and shoulder bruising from the fall. She shared Resident B had been care planned for some time for her to be gotten up for all meals and fed in her broda chair. The day of the fall, she learned Resident B was still in bed and fed breakfast in bed around 9:00 a.m. "The main reason for this is that she is a choking risk, because of her Huntington's diagnosis." The family member noted the signs on her mother's wall, related to be gotten up in the morning and to eat all meals in her chair and a turning schedule appeared the next day (7-3-23) and was informed the DON had put those in place. She added on the day of the fall, but after the fall, she observed a male staff member transfer her mother and "he scooped her up and held her like you would a baby to move her. Normally they use 2 people to move [transfer] her." In an interview with CNA 5 on 7-20-23 at 2:16 p.m., she indicated on the morning of 7-2-23, she was picking up breakfast trays, but was not assigned to Resident B's hall. "That morning she was still in bed when I was picking up trays and noticed she had not been fed yet. She is normally a morning get up. The nurse asked [name of CNA 4, Resident B's assigned CNA], why he hadn't gotten her up yet and told him to get her up. [Name of CNA 4] asked me to help feed her and I did and fed her in bed, before he got her up. He told me that he was going to get her up after I fed her. I fed her with the bed in low position, as usual, and the side rails were in the up position. The side rails were not padded at that time. I			

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	lowered the head of the bed some, not flat, when I finished feeding her. I found out about her falling from the nurse, [name of RN 7], before lunch time. I left [name of Resident B] right after I fed her to go work with my patients. Nothing was mentioned to me about how she was found. I had not moved the floor mat beside her bed when I fed her, because there's not a reason to." CNA 4 was not scheduled to work during the survey. Attempts to contact CNA 4 by telephone were unsuccessful. An investigation note, signed by the DON and dated 7-3-23, indicated CNA 4, "stated he was scheduled to get resident in question up for the morning; he stated when he left resident's bedside, the nurse and a CNA was there." An associated note, dated 7-4-23, and signed by the DON denoted the nurse on duty at the time of Resident B's fall, RN 7, stated that she asked CNA 4, "to get resident up and he [name of CNA 4] stated he wanted to smoke a cigarette first." A "Care Team Member Corrective Action Form, dated 7-11-23, and signed by the DON and Executive Director (ED) indicated CNA 4 "not taking responsibility for fall." It included a statement CNA 4 refused to sign the document, as he "was not the aid assist [sic] the resident to eat, and didn't leave her up or w/o [without] fall mat." Resident B's fall care plans indicated she was to be assisted for transfer from bed to chair and returned to bed with the assistance of 2 staff members and the use of a gait belt, effective 4-8-22. She was care planned to have the bed in the low position with a floor mat in place, effective 4-8-22. She was care planned for "2-1/2 siderails for safety," effective 4-8-22.			

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	A review of Resident B's care plans for assistance with activities of daily living, denoted she requires extensive to total assistance of one to two persons with bed mobility, effective 4-8-23, with a revision, dated 7-5-23. New interventions added on 7-7-23, included, but were not limited to assistance to bed promptly after dinner and to be up in the wheelchair for all meals. 2. The clinical record of Resident D was reviewed on 7-21-23 at 9:10 a.m. His diagnoses included, but were not limited to, rhabdomyolysis (muscle tissue breakdown, resulting in the release of myoglobin into the blood which can adversely affect the kidneys), moderate protein-calorie malnutrition, anorexia, repeated falls and age-related debility. His most recent Minimum Data Set (MDS) assessment, dated 5-29-23, indicated he had moderate cognitive impairment, was ambulatory with limited assistance from one person and used a walker or wheelchair for mobility. It indicated he had two or more falls without injury and one non-major injury from a fall since the last assessment period. It indicated he was involved with occupational therapy since 4-20-23. A progress note, dated 5-18-23, identified as a "Non Pressure Ulcer Note," indicated, "Resident reported to writer that while attempting to transfer to toilet from w/c [wheelchair] he lost his balance and hit his back on the side of the wall and toilet paper holder. Resident did not inform staff of incident at time. Stated 'I didn't think it was a big deal.' Resident can not remember exact day that this happened, stated a few days ago maybe. Resident educated that staff should be notified when this happens. NP [nursee practitioner] notified of bruise." No additional information regarding the unwitnessed fall or bruise was			

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	located in the clinical record. The next note in clinical record was dated 5-30-23 was related to a psychiatric in-house visit. In an interview with Resident D on 7-20-23 at 1:55 p.m., he indicated he has had multiple falls with minor injuries while at facility, "most of the falls were my own fault, to be honest. Just not thinking and ended up with falling. Kind of embarrassing." In an interview on 7-21-23 at 9:50 a.m., with the Director of Nursing (DON), the progress notes for Resident D were reviewed from the end of April, 2023 to the present time. The DON was unable to locate any other details, including an assessment at the time of learning of the fall or any follow-up or notifications to the Executive Director (ED), attending physician or to any responsible party, located in the clinical record related to the 5-18-23, fall. In an interview with the ED on 7-21-23 at 10:10 a.m., she indicated the skin note dated 5-18-23, which mentioned an unwitnessed fall was written by the former DON. "It was her last day working here. I could not find any other information to suggest the fall was reported to anyone else or any investigation conducted for it." The ED clarified she was unable to locate any follow-up assessment documentation. In an interview with the ED on 7-21-23 at 12:15 p.m., she indicated it was her understanding, related to post-fall follow-up, there should be an assessment made by a licensed nurse and a written follow-up note made at least daily for 72 hours. This Federal tag relates to Complaint IN00412708.			

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	3.1-37(a)			