STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155247	A. BUILDING 00 B. WING	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTHPORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227

(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 Complaints IN00382906 and IN00383061. Complaint IN00382906 - Unsubstantiated due to lack of evidence. Complaint IN00383061 - Unsubstantiated due to lack of evidence. Survey dates: September 20, 21, 22, 23, 26, and 27, 2022 Facility number: 000151 Provider number: 155247 AIM number: 100284060 Census Bed Type: SNF/NF: 70 SNF: 19 Total: 89 Census Payor Type: Medicare: 18 Medicaid: 60 Other: 11 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 30, 2022.	F 0000	To Whom It May Concern: Majestic Care of Southport recently had a recertification and state licensure survey, survey event ID **YQ4611** that occurred September 20,21,22,23,26, and 27, 2022. Our plan of correction is attached. We are requesting desk review for our citations. Please let me know if you need any additional documentation. Thank you, Edna Davenport, HFA	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edna Davenport	HFA	11/02/2022

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

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to implement new interventions to prevent falls for 1 of 4 residents reviewed for falls. (Resident 11) Findings include: On 9/26/22 at 10:33 a.m., the clinical record of Resident 11 was reviewed. The diagnoses included, but were not limited to, muscle weakness and frequent falls. A Quarterly Minimum Data Set (MDS) assessment, dated 6/27/22, indicated Resident 11 had severe cognitive impairment and the resident had two or more falls since admission. The Interdisciplinary Team (IDT) progress notes included, but were not limited to: On 2/14/22 at 9:42 a.m., indicated on 2/13/22 the resident was found on the bathroom floor. The resident indicated she fell while attempting to pull up her pants. On 4/20/22 at 9:32 a.m., indicated on 4/19/22 the resident was found lying on her left side next to her bed. On 5/3/22 at 9:19 a.m., indicated on 5/2/22 the resident had an unwitnessed fall, the resident was	F 0689	It is the practice of this provider to ensure that new interventions are put in place following a resident fall. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 11 had falls reviewed for needed interventions. MD/NP made aware of deficient practice. No new orders or changes in plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who have falls are at risk for deficient practice. DNS/Designee will complete and audit of the falls for the last 30 days to ensure that each resident has intervention is in place post fall. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	10/14/2022

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	attempting to ambulate to the bathroom with no assistance. On 6/1/22 at 11:28 a.m., indicated the resident had an unwitnessed fall on 5/29/22. Resident 11 was attempting to take herself to the bathroom unassisted. An IDT progress note, dated 7/1/22 at 9:24 a.m., indicated Resident 11 had an unwitnessed fall on 6/30/22. The resident was attempting to take self to the bathroom unassisted. An IDT progress note, dated 8/17/22 at 11:08 a.m., indicated Resident 11 had an unwitnessed fall earlier in the day. Resident had attempted to transfer self to the wheelchair. No injuries noted. The fall care plan, dated 7/24/2020 and current through 9/27/22, lacked an updated intervention to prevent further falls following Resident 11's falls on 2/13/2/2, 4/19/22, 5/2/22, 5/29/22, 6/30/22, and 8/17/22. During an interview, on 9/27/22 at 12:00 p.m., the Administrator indicated the fall care plan should have been updated after every fall. During an interview, on 9/2722 at 12:00 p.m., the Director of Nursing indicated the fall care plan should have been updated after every fall. On 9/26/22 at 10:30 a.m., the Administrator provided a policy titled Fall Management, dated October 2019, and indicated it was the current policy being used by the facility. A review of the policy indicated "Fall Management, ...4. All falls will be discussed by the interdisciplinary team to determine root cause and other possible interventions to prevent future falls. ...The care		DNS/Designee will in-service licensed staff on Fall Policy on or before October 14, 2022. DNS/ Designee will complete daily audit tool and meet with direct care staff Monday through Friday to review residents with falls, discuss updates including implementation of new intervention(s) of residents sustaining falls. This will be completed x 30 days; areas will thereafter be monitored through the fall management QA tool. Updated Kardex for residents sustaining falls will be provided to weekend staff through communication binder. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Designee will complete the Fall QA Tool for weekly x 4, bi -weekly x 2, and monthly x 4 and then quarterly continued compliance is maintained for at least 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **By what date the systemic**	

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	plan will be reviewed and updated, as necessary." 3.1-45(a)		**change will be completed?** October 14, 2022	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure a resident's enteral feeding (tube feeding) was administered as indicated by the physician's order for 1 of 3 residents reviewed for tube feedings. (Resident 5) Findings include: On 9/21/22 from 10:40 a.m. to 10:45 a.m., observed Resident 5 resting in bed. Next to the bed was an IV pole with an electronic IV pump attached. The	F 0693	It is the practice of this provider to ensure that each resident has tube feeding administered as ordered. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 5's feeding rate was corrected to match Md order	10/14/2022

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	IV pump had a bag, one half full of tan colored liquid; the tube feeding bag was labeled as Jevity 1.5 (a prescribed liquid nourishment administered through a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) and indicated that the rate of administration of the tube feeding was 45 ml/hr (milliliter per hour). The tubing was attached to Resident 5 and the device was on and running; the electronic display indicated that the tube feeding was running at a rate of 45 ml/hr. On 9/21/22 from 1:40 p.m. to 1:45 p.m., observed Resident 5 resting in bed. Next to the bed was an IV pole with an electronic IV pump attached. The IV pump had a bag, one half full of tan colored liquid; the tube feeding bag was labeled as Jevity 1.5 and indicated that the rate of administration of the tube feeding was 45 ml/hr. The tubing was attached to Resident 5 and the device was on and running; the electronic display indicated that the tube feeding was running at a rate of 45 ml/hr. On 9/22/22 from 9:45 a.m. to 9:50 a.m., observed that Resident 5 was not in room. Next to the bed was an IV pole with an electronic IV pump attached. The IV pump had a bag, 3/4 full of tan colored liquid; the tube feeding bag was labeled as Jevity 1.5 and indicated that the rate of administration of the tube feeding was 45 ml/hr. The electronic display indicated that the tube feeding was last running at a rate of 45 ml/hr. During an interview on 9/22/22 at 10:00 a.m., LPN (Licensed Practical Nurse) 1 indicated that Resident 5's tube feeding order was for Jevity 1.5 at 75 ml/hr from the hours of 5:00 p.m. through 9:00 a.m. LPN 1 observed the pump in Resident 5's room and further indicated that the IV pump was		immediately, MD/NP made aware of deficient practice. No new orders or changes in plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents that require feeding are at risk for deficient practice. DNS/Designee completed an audit of all residents that required enteral feeding during survey to ensure that feeding was being administered as ordered. No other residents were found to be affected by deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All licensed staff will be educated on following Physician orders for enteral tube feeding, provided by DNS/designee on or before October 14, 2022. IDT will complete daily audit tool to ensure that residents enteral feedings are being administered as ordered. This will be completed x 30 days on random shifts; areas will thereafter be monitored through the enteral nutrition QA tool. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	last running at 45 ml/hr and the tube feeding bag was labeled for 45 ml/hr which was not the correct rate. On 9/22/22 at 11:25 a.m., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (a stroke) and hemiplegia (muscle weakness or partial paralysis on one side of the body) affecting left non-dominant side. Resident 5's diet order was NPO (nothing by mouth) with a start date of 8/26/22 and no end date. A Physician order, dated 9/15/22 with no end date listed, indicated Resident 5 was prescribed an enteral feed order for every evening and night shift for Jevity 1.5 at 75 ml/hr to start at 5:00 p.m. and to be off at 9:00 a.m. During an interview on 9/22/22 at 1:30 p.m., the Administrator indicated that the observed tube feeding rate was not correct for the resident. On 9/23/22 at 8:45 a.m., the Administrator provided a copy of the Enteral Feeding policy, dated November 2018, and indicated it was the current policy in use by the facility. A review of the policy indicated that tube feeding orders are to be confirmed by the nurse to include the correct volume and rate of administration. 3.1-47(a)(2)		The DNS/Designee will complete the Enteral Nutrition QA Tool weekly x 4, bi-weekly x 2, and monthly x 4 and then at least quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **By what date the systemic change will be completed?** October 14, 2022	