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	08/19/2022

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 the Investigation of Complaints IN00386340, IN00387401, IN00387782 and IN00384389. Complaint IN00386340 - Substantiated. No deficiencies related to the allegation(s) are cited. Complaint IN00387401 - Substantiated - Federal/state deficiencies related to the allegations are cited at F760. Complaint IN00387782 - Unsubstantiated due to lack of evidence. Complaint IN00384389 - Substantiated - Federal/state deficiencies related to the allegations are cited at F921. Survey dates: August 17, 18, and 19, 2022 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 22 Medicaid: 79 Other: 2 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 9-16-22 to the complaint survey completed on 8-19-2022. We respectfully request a paper review and will provide any additional information requested.	

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

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	Quality review completed on August 30, 2022.			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. During observation, interview, and record review, the facility failed to keep the resident free of any significant medication error when the resident was given 10 out of 10 medications 2 hours late and was distributed her medications along with other medications carried into the resident room by the nurse for 1 of 2 residents observed medications administered. (Resident G) Findings included: During an interview 8/18/2022 at 12:45 p.m., with Resident G she indicated the facility staff do not give her medications to her on time. She indicated she was supposed to get her morning medications with her breakfast, and she had not received them today. She indicated she needed her medications, and she was not feeling well because they were late. An observation on 8/18/2022 at 1:09 p.m., Resident G was given her morning medications late by Registered Nurse (RN) 2. They were scheduled to be given between 6 a.m. to 10 a.m.). During the administration of the medications, the resident asked RN 2 if she was getting a breathing treatment because RN 2 had a breathing treatment medication and another cup of pills in his hand. RN 2 indicated he always made up the medications for both residents in a room and took them in for distribution at the same time. RN 2 indicated he knew the medications were late and should have been given by 11:00 a.m. for the	F 0760	**F 760 Resident are free from significant medication errors** 1. What corrective action will be accomplished for those resident(s)found to have been affected by the deficient practice: a. MD notified regarding late medication administration. b. All nurses educated on asking for assistance if running behind administering medication. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a. Other residents have the potential of being affected by the deficient practice. b. An audit was completed of medication administration times, MD notified of late medication administration for those affected. c. Staff nurse educated regarding 5 rights of medication administration. d. All nurses educated regarding 5 rights of medication administration. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	09/16/2022

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	resident. RN 2 indicated he did not know it was wrong to pass multiple medications for residents in the same room at the same time. During an interview on 8/18/2022 at 1:26 p.m., with the Director of Nursing, she indicated the staff member should have prepared one resident's medication pass at a time and distributed it to the resident per MD orders. She indicated the staff was not to prepare more than one resident's medications at a time. DON indicated she was not aware the staff member needed assistance with medications. DON indicated there was staff in the facility to assist the staff member and medications should not be delayed in distribution. During a record review on 8/18/2022 at 4:04 p.m. of the medication pass for Resident G the following medications were given late: Megestrol Acetate Tablet 40 milligram (mg) - give one tablet by mouth (PO) one time a day (QD) 600-1000 for excessive and frequent menstruation with irregular cycle was given on 8/18/2022 at 12:50 p.m. Metoprolol Tartrate Tablet 100MG - give one tablet PO x 2 daily (BID) 600-1000 for hypertension was given on 8/18/2022 at 12:48 p.m. Provera Tablet 10 MG -give 2 tablets PO QD 600-1000 for excessive and frequent menstruation with irregular cycles was given on 8/18/2022 at 12:50 p.m. Famotidine Tablet 20MG -give one tablet PO BID 600-1000 for Gasto-esphageal reflux disease without esophagitis was given on 8/18/2022 at 12:48 p.m. Ferrous Sulfate Tablet 325MG - give one tablet PO BID 600-1000 for excessive and frequent menstruation and irregular cycle was given on 8/18/2022 at 1:27 p.m. Furosemide Tablet 20MG- give one tablet PO QD		recur: a. Education was completed for nursing staff regarding Medication administration and the 5 rights of medication administration. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a. The DON or designee will educate all nurses in orientation regarding the 5 rights of medication administration. b. The DON or designee will conduct medication administration check off, prior to administering medications with the facility. c. The DON or designee will perform audits weekly for 4 weeks, every other week for 8 weeks, and monthly for 3 months, for missed or late medications along with corrective action for identified non-compliance. d. Results will be submitted to QAPI monthly.	

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	600-1000 for heart failure was given on 8/18/2022 at 12:48 p.m. Amlodipine Besylate Tablet 10MG - give one tablet PO QD 600-1000 for hypertension was given on 8/18/2022 at 12:47 p.m. Celexa Tablet 40MG - give one tablet PO QD 600-1000 for depression was given on 8/18/2022 at 12:48 p.m. Culturelle Capsule - give one capsule PO QD 600-1000 for loose stools was given on 8/18/2022 at 12:47 p.m. Wellbutrin XL Tablet extended release 24 hour 150MG - give 2 tablets PO QD 600-1000 for depression was given on 8/18/2022 at 12:47 p.m. A facility policy titled, "Administering Medications," dated as last reviewed 4/2019 and provided by the DON on 8/18/2022 at 2:04 p.m., indicated, "...4. Medications are administered in accordance with prescriber orders, including any requested time frame...7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)...i. The DON designee will contact the provider, resident representative and/or the authorized family members e. Notification may be made via telephone or face- to- face...c. The nurse will record in the progress notes, the name of the person called, the time of each attempt to contact, and the telephone number(s) attempted...." This Federal tag relates to the Complaint IN00387401. 3.1-48(c)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	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 a clean, sanitary, and home like environment related to 7 of 7 resident rooms observed, 1 of 2 hallways observed, 1 of 1 shower room observed, and 1 of 1 assisted dining room observed (Rooms 200, 237, 233, 147, 131, 117 and 120). Findings include: During the initial tour on 8/17/2022 at 12:50 p.m., the following was observed: a.) The assisted dining room for the 200 hall had cracked window blinds, the garbage can was overflowing and did not have a lid. Dirty food trays were left out and the cabinet drawer underneath the tray was unhinged and missing a drawer. The staff had their personal belongings, lunch bags and open drink cups on the tables in the assisted dining room b.) Room 200 was observed to have cracked window blinds, the window ledge had a pink stain, chipped paint and debris. The bathroom toilet had waste in it and the bottom of the door had peeled away from the bottom of the door - backside edge was warped creating a hazard for the resident. c.) Room 237 was observed to have walls needing painting - chipped and peeled. The window ledge was chipped and cracked. d.) The shower area for the 200 hall opened for resident utilization had tiles missing from the floor area. There were 15 floor tiles missing and 13 tiles were cracked and chipped. The floor was warped	F 0921	F921 The facility will ensure a clean, sanitary and home like environment. p="" paraid="1050729855" paraeid="{82964fbf-6194-4287-a315-d83b714371a4}{118}"> **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The dining room for 200 hall blinds were replaced, garbage disposed of and garbage can replaced with lid. Cabinet drawer was fixed. Staff educated on where to keep personal belongings. Room 200 blinds replaced, window edge cleaned. Bottom of door repaired. Room 237 was painted. Shower area for 200 hall tiles were replaced where needed. The walls were cleaned. Overhead lights in room 210 and 215 were tightened and secured. The overhead lights near 223 and 212 were fixed along with the ceiling tiles. Room 233 cleaned	09/16/2022

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	and unlevel. The walls were stained with dirt and debris. e.) The overhead lights in the hallway of rooms 210 and 215 were lose and 30 panels were not secure. The overhead light in the hallway near the rooms 223 and 212 was not working. f.) Room 233 was observed to have debris, food, briefs and papers scatted on the floor. The toilet was clogged with feces and had an odor. The door need painting and had multiple scratches. g.) The hallway outside the staff lounge, the overhead light cover was missing, warped and 20 overhead panels were not secure. h.) Room 147 was observed to have the ventilation grill broken and blankets and papers on top of broken grill which had fallen into the ventilation container. A hole the size of 2 silver dollars was observed to be in the wall next to the doorway. The bathroom door was unhinged- not secure. The bathroom toilet hinge area was rusted dirty and had debris and old feces in the hinges. i.) Room 131 had cracked window blinds, a dirty ventilation grill, a pillow on the floor near the windowsill and mold on the ventilation grill countertop. The bed area near the resident's bed had scraped, peeling, and chipped paint on the wall. j.) Room 117 was missing a light cord for the light over the bed area so the resident was not able to access the light, the toilet bowl had feces and the sink was clogged and full of dirty water. The ventilation grill was broken and in the well of the ventilator. The window ledge was dirty, had debris and was broken on the corner closest to		and maintained and door was repainted. Hallway by staff lounge ceiling panels secured and or replaced, light cover was replaced. 147 ventilation grill was replaced and items removed from the top of it. Hole was patched and painted. Bathroom door was fixed and area around door cleaned. Room 131 window blinds were replaced, vent grill cleaned, counter top cleaned and wall painted. Room 117 light cord was replaced, sink/toilet cleaned, vent grill cleaned and replaced. Window ledge was cleaned and fixed. room 120 overhead door was fixed Room was cleaned and organized. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All other areas of the building were reviewed and maintained as necessary to ensure a clean, sanitary and home like environment. The dining room for 200 hall blinds were replaced, garbage disposed of and garbage can replaced with lid. Cabinet drawer was fixed. Staff educated on where to keep personal belongings. Room 200 blinds replaced, window edge cleaned. Bottom of door repaired. Room 237 was painted. Shower area for 200 hall tiles were replaced where needed. The walls were cleaned.	

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	the resident's bed. k.) Room 120 had a broken overhead door arch, and the hallway outside was congested with 2 broken wheelchairs, 2 over bed tables with dirty food trays, a dirty floor mat, and an oxygen concentrator During an interview on 8/17/2022 at 3:30 p.m., the Director of Nursing indicated the staff had been told not to leave personal items in the assisted dining rooms with easy access for the residents. The hallways should be cleared of clutter, and the areas observed should be clean and repaired. The facility was in the process of repairs due to a recent Life Safety survey 2 weeks ago. The areas observed needed to be cleaned by housekeeping. The staff were supposed to notify the administration if resident rooms needed repair. During an interview on 8/17/2022 at 4:02 p.m. with the Acting Administrator, she indicated she was aware of the facility needing repairs but was not aware of the observations during the 8/17/2022 tour of the facility. The current policy titled, "Method of Cleaning", undated, received on 8/18/2022 at 2:04 p.m., from the Director of Nursing indicated, "...TOP DOWN: always start cleaning surfaces, ledges, shelves, etc., at the top and work your way down. Clean the face of areas as well...Restrooms-address the same as a room, paying careful attention to the sink and commode. Infection control is critical here. Avoid cross contamination: always clean the sink first, then the toilet...Check privacy curtains, linens and overall condition the room(Note any Maintenance concerns)...Remove all debris from the floors, counters, and edges...Remove all trash and replace liners as needed...."		Overhead lights in room 210 and 215 were tightened and secured. The overhead lights near 223 and 212 were fixed along with the ceiling tiles. Room 233 cleaned and maintained and door was repainted. Hallway by staff lounge ceiling panels secured and or replaced, light cover was replaced. 147 ventilation grill was replaced and items removed from the top of it. Hole was patched and painted. Bathroom door was fixed and area around door cleaned. Room 131 window blinds were replaced, vent grill cleaned, counter top cleaned and wall painted. Room 117 light cord was replaced, sink/toilet cleaned, vent grill cleaned and replaced. Window ledge was cleaned and fixed. room 120 overhead door was fixed Room was cleaned and organized. **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:** The executive director and/or his designee will complete daily rounds weekly for 4 weeks, 3x a week rounds for 5 months and ongoing.. All information from audit during rounds will be documented and reviewed the following day during morning stand	

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	This Federal tag relates to the Complaint IN00384389. 3.1-19(e)		up. All identified areas will be immediately remedied. Concerns will be brought to QAPI and addressed accordingly. Administrator to montior.	