STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404698, and IN00405358. Complaint IN00404698 - No deficiencies related to the allegations are cited. Complaint IN00405358 - Federal/state deficiencies related to the allegations are cited at F755. Survey dates: April 26, 27, and 28, 2023 Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census Bed Type: SNF/NF: 93 SNF: 5 Total: 98 Census Payor Type: Medicare: 5 Medicaid: 71 Other: 22 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 9, 2023.	F 0000	Majestic Care of Avon is respectfully requesting desk review rather than revisit on or after May 18, 2023 . Please feel free to contact me if you feel that additional information or documentation would assist you in that process. I can be reached at 317-745-2522. Thank you, Rachel, DNS	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Cremeans-Herald	DNS	05/18/2023

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	residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, interview, and record review, the facility failed to ensure routine medications were available and dispensed according to physician's orders and stored in an organized manner for 3 of 4 residents reviewed for medication administration (Residents B, X, and Z). Findings include, 1. During an interview on 4/26/23 at 10:09 a.m.,	F 0755	F0755 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident B has been discharged from the facility. ·Resident X medication regimen was reviewed, pharmacy notified, all prescribed medications are in	05/18/2023

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	Resident B indicated he was not being given his medications correctly causing him to be "drugged." He also had either been out of his methocarbamol or someone stole it, but either way his feet and ankles had severe pain due to being stiff. A Grievance/Concern log, dated 4/1/23, indicated Resident B reported his medication methocarbamol (generic for Robaxin a muscle relaxant) was unavailable. Resident B's record was reviewed on 4/26/23 at 11:16 a.m. Diagnoses on Resident B's profile included but were not limited to schizoaffective disorder (a mental health condition with a combination of symptoms of schizophrenia and mood disorder such as depression or bipolar disorder), aftercare following surgery on the nervous system, pain, and hereditary and idiopathic neuropathy (symptoms to include pain, numbness, tingling and muscle weakness, and loss of sensation to a limb). A Physician's order, dated 3/21/23, indicated methocarbamol 750 milligrams (mg) give 2 tablets by mouth every 6 hours for rigidity. A medication administration record (MAR), dated March 2023, indicated documentation of 116 tablets of the medication were administered 4 times daily as ordered at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. A pharmacy medication delivery manifest, dated 3/17/23, indicated 112 tablets of methocarbamol 750 mg were delivered, and when compared to the March 2023 MAR the 2 doses ordered for 12:00 p.m. and 6:00 p.m. documented on 3/31/23 could not have been administered as there was no		stock and being administered timely. Resident X was assessed with no negative outcomes. ·Resident Z medication regimen was reviewed, pharmacy notified, all prescribed medications are in stock and being administered timely. Resident Z was assessed with no negative outcomes. 1. How will other residents having the potential to be affected by the same deficient practice 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. ·100% medication and treatment cart audit completed 5/16/2023 by pharmacy services to ensure all medications ordered are in stock. ·DNS/ED will meet with pharmacy provider on 5/16/2023 to go through root cause analysis on medication unavailability. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? ·All nursing staff were educated on the Medication Reordering Process and following physician orders/plan of care by the	

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	medication available in the facility. A MAR, dated April 2023, indicated documentation of the 4 doses of methocarbamol on 4/1/23 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., were not administered due to "other" and "hold". A Progress Notes, dated 4/1/23 at 9:12 a.m., indicated the resident stated he had not had his methocarbamol for several days. Upon checking on medication cart and eMAR (electronic medication administration record) it was noted that resident has been given medication up until this a.m. Pharmacy called and requested methocarbamol be sent STAT (sent out immediately). The resident was told the medications would be sent from pharmacy as soon as they had a carrier who could bring it. A progress notes, dated 4/1/23 at 11:16 a.m., indicated staff met with the resident to assure staff were meeting his needs. The resident indicated awaiting medication from pharmacy. The Nurse Practitioner (NP) for the medical director was notified of the missing medication. Care plans for Resident B, indicated the resident had pain related to diagnoses of hereditary and idiopathic neuropathy and recent surgery, and behaviors related to paranoia and schizoaffective disorder. The first intervention was for the resident to receive his medications as ordered. During an interview on 4/28/23 at 11:48 a.m., the Director of Nursing Services (DNS) indicated the floor nurses were responsible for ordering medications. The nurse could re-order medications by clicking on the order button on the screen of the electronic MAR, then should call		DNS/designee on 5/18/2023. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? ·QAPI tool Medication Cart audit will be completed weekly x 4 weeks, bimonthly 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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	the pharmacy if noticing medications were not available. There had been a few days the Internet kept going on and off after a bad storm. On Friday 3/31/23 night or Saturday 4/1/23 she had been made aware Resident B's methocarbamol was either missing or not unavailable. The Assistant Director of Nursing (ADNS) was in the facility on 4/1/23 and was asked to check on the availability of the medication, and it was not available. The ADNS contacted the pharmacy and asked that the medications be sent STAT. 2. During a random medication observation on 4/28/23 at 9:00 a.m., Qualified Medication Aide (QMA) 7 was observed to take more than 33 minutes to set up Resident X's medications before administering. The following concerns were observed: a. Tylenol Extra Strength 500 mg (analgesic for minor aches and pains or to reduce fever) tablet give 2 by mouth twice a day for pain. The medication label on the card in the medication cart read Tylenol Extra Strength 325 mg, indicating the wrong dose of medication was in the cart. b. Carboxymethylcellulose Sodium 0.5% solution (temporary relief of burning, irritation, and discomfort due to dry eyes) instill 1 drop in both eyes twice a day for dry eyes. The medication was unavailable. c. Eliquis 2.5 mg (an anticoagulant to prevent and treat blood clots) give 1 tablet by mouth twice a day related to chronic atrial fibrillation. The medication was unavailable. d. High Pot Multivitamin/Beta-Car tablet (labeled as high potency with beta carotene and potentially higher doses of potassium) give 1 by mouth once daily for supplement. The medication was unavailable. The Unit Manager pulled a card of medication with a label reading Theres-M tablet and indicated the medication was a therapeutic			

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	interchange, although documentation to verify was not provided. e. Torsemide 10 mg (diuretic) give 2 tablets daily, and Fluticasone Furoate 100-25 micrograms (mcg) (a steroid nasal spray to treat pain, itching, and swelling, or asthma attacks) 1 puff daily were not available in the medication cart, but later found in back-up storage on another medication cart. Resident X's record was reviewed on 4/28/23 at 10:40 a.m., Diagnoses on Resident X's profile included, but were not limited to, vascular dementia (brain damage caused by multiple strokes and causes memory loss), chronic systolic congestive heart failure (occurs when the heart does not bump blood effectively), chronic atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (high blood pressure), and chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breath). During an interview on 4/28/23 at 9:58 a.m., QMA 7 indicated she did not usually administer medication on the 700 hallway and could not answer as to why Resident X's medications had not been stocked in the cart, had not been re-ordered, or were eventually found stored in random drawers on 2 separate carts. 3. During a random medication pass observation by Licensed Practical Nurse (LPN) 8, on 4/28/23 at 9:48 a.m., Resident Z was found to be missing his routine clonazepam 0.5 mg (used to treat anxiety). Resident Z's record was reviewed on 4/28/23 at 10:56 a.m. Diagnoses on Resident Z's profile included, but were not limited to, adjustment disorder with mixed anxiety and depression (mixed anxiety and depression could include behavioral			

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	issues such as acting rebellious, destructive, reckless, or impulsive), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depressive disorder (severe, ongoing depression that could appear as outbursts, irritability, frustration, loss of interests or pleasure in most normal activities), personality disorder (mental disorder in which the person has rigid and unhealthy pattern of thinking, functioning, and behaving), and a dependent personality disorder (a type of anxious personality disorder where people often feel helpless, submissive or incapable of taking care of themselves). A Physician's order, dated 3/27/23, indicated clonazepam 0.5 mg give 1 tablet by mouth two times a day related to generalized anxiety disorder. A Narcotic Administration Record for clonazepam 0.5 mg indicated Resident Z had received 27 doses from the pharmacy on 4/12/23. Documentation indicated the medication was administer twice daily as ordered with the last available dose administered on 4/27/23 at 8:00 a.m. The resident record lacked documentation there was medication available or administered on 4/27/23 at 8:00 p.m. or 4/28/23 at 8:00 a.m. Progress notes for Resident Z lacked documentation after 4/24/23. The resident record lacked documentation the physician or resident were made aware clonazepam 0.5 mg was unavailable, or that it had been re-ordered. During an interview on 4/28/23 at 3:15 p.m., the DNS indicated Resident Z had received his clonazepam as ordered due to it having been pulled from the pyxus (emergency medication storage back-up machine). The NP had been in the			

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	facility on 4/27/23 and wrote a new script for the clonazepam. The DNS could not answer as to why the nurses were not re-ordering medications timely, but indicated the NP was in the facility 2-3 days per week and available for medication re-orders as needed. On 4/28/23 at 1:35 p.m., the DNS provided a Medication Orders policy, dated 2/1/18, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy: To define the process for ordering and dispensing prescriptions in accordance with State and Federal regulations. Procedure: 1) All medication orders must be faxed to the pharmacy ...2) New medication orders faxed prior to standard cut off times [see policy #1.03] are assumed to begin administration during next medication pass time after the next standard delivery ...17) Some facilities may enlist the use of eMAR and electronic signatures." This Federal tag relates to Complaint IN00405358. 3.1-25(a)			