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	07/02/2021

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

(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 IN00356050, IN00356372, and IN00357035. This visit included a COVID-19 Focused Infection Control Survey. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00356050 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00356372 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00357035 - Substantiated. Federal/state deficiencies related to the allegations are cited at F584. Unrelated deficiencies are cited. Survey dates: June 30, and July 1, and 2, 2021. Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census Bed Type: SNF: 9 SNF/NF: 85 Total: 94 Census Payor Type: Medicare: 9 Medicaid: 72 Other: 13 Total: 94 These deficiencies reflect State Findings cited in	F 0000	Majestic Care of Avon respectfully request a desk review on or after 7/21/21.	

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

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on July 12, 2021.			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;			

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	§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure resident rooms and care areas were kept in a clean, homelike environment for 6 of 14 resident rooms observed for cleanliness (Residents B, D, G, J, K, L). The facility also failed to maintain staffing to provide housekeeping services, which had the potential to affect 94 of 94 residents who resided at the facility. Findings include: On 6/30/21 at 9:58 a.m., a communal resident shower room was observed. The floors inside the shower room and 2 observed shower stalls were dry. A shower chair was observed with 2 bath towels unfolded and placed over the seat of the shower chair. Another towel, unfolded, was on the floor. On the floor, in the corner of one of the shower stalls was a washcloth with large amounts of brown discoloration on the cloth. Both shower stall drains had a thick layer of dried hair over the floor drain grates. During an interview on 6/30/21 at 10:18 a.m., Certified Nursing Aide (CNA) 9 indicated the facility's housekeeping staff was short at that time. She was not sure if there was a housekeeper working in the building that day. On 6/30/21 at 10:21 a.m., Resident D's room was observed. The floor was sticky, causing shoes to	F 0584	Majestic Care of Avon respectfully request a desk review on or after 7/21/21. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. The shower room was deep cleaned on 7/21/21 by the housekeeping supervisor. 2. Resident B, D, G, J, K, L's rooms were deep cleaned on 7/21/21. 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 have potential to be affected by this alleged deficient practice. 1. All resident rooms were assessed for cleanliness on 7/21/21. 2. A new housekeeping supervisor was appointed on 7/2/21. 3. A daily cleaning schedule and a deep cleaning schedule was developed and implemented on 7/21/21. 4. All residents rooms were assessed for hazards on 7/1/21. What measures will be put into place and what systemic changes will be made to ensure that the	07/21/2021

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	stick to the floor when walked upon. Random bits of food and other dirt and debris were scattered about floor, throughout the resident's room, but specifically concentrated under the resident's bed. Inside Resident D's bathroom, which was accessed from inside the resident's room, was a large area, greater than the size of a basketball, of dark brown liquid and staining coming from the back of toilet, that extended onto the bathroom floor. On 6/30/21 at 10:32 a.m., Resident B's room was observed. Cobwebs were observed on the top of the window seal. There were observed food and other debris on the floor. Inside the resident's bathroom, which was attached to the resident's room, were dirty washcloths left on the shower floor. The toilet had brown debris inside the toilet bowl, and around the base of the toilet. The bathroom trash can had discarded items in it, but no trash bag was placed in the trash can. A toothbrush was observed in a small plastic container near the sink, with a thick white substance noted inside the container. During an interview, on 6/30/21 at 10:35 a.m., Licensed Practical Nurse (LPN) 6 indicated she had concerns with resident rooms not being cleaned. The facility did not have any housekeepers. They used to have one, but she was supposed to clean the rooms and do laundry for all the residents. The housekeeper had quit and had not been replaced. On 6/30/21 at 12:23 p.m., Resident L was observed as she sat at a desk in her room. The resident wore a helmet and was observed standing up and sitting down multiple times. A plastic face shield and a towel were on the floor, next to the resident's chair. Dirt and debris were observed on		deficient practice does not recur; 1. All staff were educated on reporting environmental issues to the Executive Director immediately on 7/21/21. 2. The IDT will make rounds daily to ensure rooms are clean and homelike through the Magic Moments Program. Any issues identified will be brough to the Executive Director. 3. Any team member working in housekeeping will receive a job specific orientation prior to working. 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; Environmental QAPI tool will be completed weekly X 4 weeks, monthly for 6 months and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	

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the floor throughout the resident's room.

During an interview, on 6/30/21 at 12:36 p.m., Resident G's room was observed. He indicated he had been at the facility for a couple months. A bedside table was placed next to the resident's bed, with a meal tray of partially eaten food. Resident G indicated the food on his bedside table was from breakfast that morning. He had not received lunch yet. The floors throughout the resident's room were sticky when walked upon. Candy wrappers, large collections of dust, and multiple areas of dirt were visible on the floor throughout the resident's room. He indicated he did not like to walk around his room much because the floors were sticky. His bathroom was also dirty and had been dirty for about a week. He told the staff he had gotten sick in the bathroom last week, and the toilet was dirty, but no one had come in to clean it. He was supposed to shower in his bathroom (connected to the resident's room) but did not like to because it was dirty. The facility had been working shorthanded for quite a while. He did not think there was a housekeeper. Resident G's bathroom was observed to have thick, dark brown debris around the base of the toilet. The shower stall had multiple areas of dirt and discoloration. The bathroom floor was sticky when walked upon.

On 6/30/21 at 12:50 p.m., an empty resident room was observed. The floor throughout the room was sticky, shoes stuck to the floor when walked on. There were moderate amounts of dust and debris on the floors. Dark brown debris and dirt were observed all around the perimeter of room, and thick layers of built-up debris and discoloration where the floor met the rubber base board. Inside the bathroom connected to the resident room, there was a thin layer of dark brown debris and

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dirt around the base of the toilet.

During an interview, on 6/30/21 at 2:52 p.m., the Director of Nursing Services (DNS) indicated, the interim Executive Director (Interim ED) and the Maintenance Director were in charge of housekeeping at that time. The housekeeping supervisor quit over the weekend. She indicated the Activities Director was working as the housekeeper that day. Nurses, the interim ED, CNAs, and PCAs (Patient Care Assistants) had all been doing shifts in housekeeping. The DNS indicated she was not sure how the clinical staff were trained to clean the rooms and use the cleaning products.

During an interview, on 6/30/21 at 2:58 p.m., the Interim ED indicated housekeeping had been an issue for the past 30 days. The housekeeping supervisor walked out over the weekend. PCAs were brought in to serve as housekeepers and provide laundry services. The interim ED had also helped clean resident rooms. The facility tried to keep clinical staff on clinical duties, but sometimes people had to do other things. He was not sure if the PCAs had been trained on how to properly clean the residents' rooms. There was no schedule for cleaning at that time due to the staffing concern. The last thirty days the clinical staff had been helping with housekeeping.

During an interview, on 7/1/21 at 8:56 a.m., Resident J's room was observed. He indicated no one ever cleaned his room. When he saw a broom in the hall, he would grab it and sweep the floor in his room. Resident J's floor was observed with multiple areas of dust, dirt, and food debris. The floor was sticky when walked upon.

During an interview on 7/1/21 at 9:11 a.m.,

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Resident K's room was observed. He indicated housekeeping did not clean. His trash can was emptied by the nursing staff, but that was it. He had been at the facility for about 6 weeks and his floors had been cleaned once. Resident K's floors were observed with multiple areas of visible dirt and debris throughout the room. The floors were sticky when walked upon. A couple weeks ago he sustained an injury to his foot that had recently been operated on. He then pointed to a faded, irregular shaped, soccer ball sized, dark red spot in the middle of the nursing unit hallway and indicated that was where his foot bled onto the floor a couple weeks ago. Resident K's bathroom, which was connected to his room, was observed. The floors were sticky when walked upon. Dark brown discoloration was observed inside the toilet bowl and surrounded the base of the toilet.

During an interview with LPN 29 on 7/2/21 at 2:12 a.m., he indicated staffing was a big concern at the facility. The facility had no housekeeping staff. Even before the housekeeping director quit the residents had complained about their rooms being dirty. The housekeeping supervisor was the only person doing any of the housekeeping and laundry for the entire facility. Nursing staff tried to clean as they saw things, but they often did not have time to clean because they needed to do resident care. The resident rooms had become dirtier over time, but staff just could not get to the cleaning.

On 7/2/21 at 10:51 a.m., the interim ED provided a document titled, "Housekeeping Checklist" that listed the nursing units of the facility, and a checklist for areas of the resident room to be cleaned. Each document was blank. He indicated there were no completed checklists because they did not have a housekeeping director, they were

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	short staffed, and just trying to keep the rooms as clean as possible so documentation was not being completed. On 7/2/21 at 1:53 p.m., the DNS provided a policy titled, "Cleaning and Disinfection of Environmental Surfaces," dated August 2019. The DNS indicated this was the current policy in use by the facility at that time. The policy indicated, " ...9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled...." On 7/2/21 at 4:13 p.m., the interim ED provided a policy titled, "Quality of Life - Homelike Environment", dated revised May 2017. The interim ED indicated this was the current policy in use by the facility at that time. The policy indicated, "Residents are provided with a safe, clean, comfortable and homelike environment... 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary, and orderly environment...." This Federal tag relates to Complaint IN00357035. 3.1-19(f)(5) 3.1-19(g)(1)			
F 0689 SS=J	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	Hazards/Supervision/Devices §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. A. Based on observation, interview, and record review, the facility failed to ensure a resident with a history of suicidal ideation (thinking about or planning suicide) and verbal threats of harming himself was supervised and free from items that could be used to harm himself for 1 of 3 residents reviewed for behavioral symptoms which resulted in an immediate jeopardy when Resident D while on 15-minute checks injured himself by breaking a glass plate and cutting his neck and verbalized he would commit suicide if he did not leave the facility; and after verbalizing threats of suicide again and while on 15 minute checks Resident D stabbed himself in the abdomen multiple times with a fork and was observed with a corded telephone in his room during multiple observations. B. Based on observation, interview, and record review, the facility failed to ensure a master code to secured doors was not provided to a resident for 1 of 3 random resident interviews and observations (Resident H). C. Based on observation, interview, and record review, the facility failed to ensure 2 of 3 memory care (MC) biohazard rooms were locked, one with a bottle of Restroom Disinfectant (hazardous chemical for cleaning) for 1 of 2 observations of	F 0689	Majestic Care of Avon respectfully requests a face to face IDR . The current statement of deficiencies on the 2567 omits significant information and therefore misrepresents the care and services administered by the provider to its residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. All master door codes were changed on 7/2/21 by the Maintenance Director. 2. All biohazard doors were properly locked immediately upon notification. 3. Resident D was assessed for injuries on 6/30/21 and placed on 1:1 staff supervision until the time of his discharge.	07/21/2021

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	the memory care. The immediate jeopardy began on 5/6/21 when Resident D made verbal threats of suicide and was placed on 15-minute checks. On 5/7/21 Resident D had a glass plate in his room unsupervised that he broke and cut his neck and verbalized he would commit suicide if he did not leave facility. He was sent out for psychological services on 5/8/21 and returned on 5/26/21 with 15-minute checks. On 6/10/21 Resident D indicated he would kill himself. On 6/11/21 resident was attempting to remove pictures from the wall. On 6/28/21 family requested the telephone be taken out of the resident's room. On 6/30/21 resident indicated he had stabbed himself in the abdomen with a fork a week ago, his abdomen was observed with bruising and pinpoint wounds; and the resident was observed with a corded telephone in his room multiple times before being sent out to the hospital. The Interim Executive Director (ED), Director of Nursing Services (DNS), and Corporate Consultant were notified of the immediate jeopardy at 5:49 p.m. on 7/1/21. The immediate jeopardy was removed on 7/2/21 at 4:40 p.m., but noncompliance remained at a lower scope and severity of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: A. During an observation, on 6/30/21 at 10:21 a.m., Resident D was observed in his room sitting on his bed, no call light was observed in the resident's room. The resident indicated a staff member had told him his family did not want him to come home and they did not "love him anymore." He was unable to remember the staff member's name but believed it to be someone "in charge of things" at the facility. When the staff		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 have potential to be affected by this alleged deficient practice. 1. All biohazard doors were checked to ensure they were properly secured on 7/2/21. 2. All master door codes were changed on 7/2/21 by the Maintenance Director. 3. All residents that reside in the facility were assessed for suicidal ideation on 7/1/21. 4. All residents rooms were assessed for hazards on 7/1/21. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 1. All staff were educated on not giving residents the master door codes on 7/21/21 by the DNS/Designee. All staff will be	

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	member made the statement, Resident D stabbed himself in the abdomen with a fork. At that time, he pulled up his t-shirt and exposed his abdomen. An area was observed to the resident's left middle, lower quadrant that was oblong shaped with dark purple discoloration noted around the border. The discoloration lightened toward the center, into a light green then yellow and lead to the resident's skin color. In the center of the flesh-colored area was five ball point pen sized puncture marks that were dark red in color and appeared shallow. A telephone was observed in the resident's bedside table drawer. The telephone had a stretchy coiled cord from the base to the receiver and cord connected to the bottom of the base of the phone and was draped out of the drawer, hung down the side of the bedside table, and was connected to the wall. The resident indicated he was not supposed to have a call light because the "staff were afraid," he would choke himself. The resident's bathroom was observed to have a red emergency pull cord that hung on the wall. During an interview, on 6/30/21 at 11:47 a.m., Patient Care Associate (PCA) 7 indicated Resident D had not had any behaviors that she was aware of and if resident had behaviors the staff were required to report it to the nurse in charge of caring for the resident. During an interview, on 6/30/21 at 11:50 a.m., Licensed Practical Nurse (LPN) 6 indicated Resident D had an order for 15-minute checks and had not had a behavior since the time he had thrown things. She was not aware if the resident had ever tried to harm himself while at the facility. The resident had behaviors on occasions. She believed it was because the resident was frustrated because his family would not tell him if he had to live at the facility permanently. She was		educated upon hire, quarterly and as needed. 2. All staff were educated on ensuring all biohazard doors are locked at all times on 7/21/21 by the DNS/Designee. All staff will be educated upon hire, quarterly and as needed. 3. All staff was initially educated on behavior management on 7/1/21 and again on 7/21/21 by the DNS/Designee. All staff will be educated on behavior management upon hire, quarterly and as needed. 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; Environmental QAPI tool will be completed weekly X 4 weeks, monthly for 6 months and quarterly thereafter by the DNS/Designee. Behavior Management QAPI tool will be completed weekly X 4 weeks, monthly for 6 months and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance	

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	unaware of what interventions his care plan had and how to access his care plans. She was able to redirect the resident by talking to him. The resident was alert and oriented. During an observation, on 6/30/21 at 11:55 a.m., Resident D was observed in his room on the telephone. A stretchy coiled cord and a cord connected to the bottom of the base of the phone was draped over the side of the bedside table and connected to the wall. No staff were observed in the resident's room at this time. During an observation, on 6/30/21 at 12:21 p.m., Resident D was observed ambulating down the 800 hall with a walker. Resident D indicated he had to 'get out of this place," and he could not be kept against his will anymore. He proceeded to exit the doors off the unit down the hallway towards the front entrance area. Staff attempted to redirect the resident and he continued off the unit. The Director of Nursing Services (DNS) was able to stop the resident before he entered the main lobby area and asked him what was going on. The resident sat down on the floor and indicated it was another resident that had "triggered" his mood. The resident was assisted back to his room. At 12:33 p.m. Resident D's lunch tray was delivered. A plastic plate and plastic utensils were noted on the resident's tray. The resident was observed to have a telephone in his room. No staff were observed to be providing one on one (1:1) care at this time. During an interview, on 6/30/21 at 2:58 p.m., the Interim Executive Director (ED) indicated Resident D had voiced prior he did not like the social worker and felt the social worker had not been truthful with him. During the interview a resident was heard from the hallway getting loud and		is not achieved an action plan will be developed.	

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indicated he was leaving the facility. The Interim ED checked to see what was going on and indicated it was Resident D who was being assisted by staff. At 3:15 p.m. an ambulance and fire truck were observed at the facility to transfer Resident D to the hospital emergency room for evaluation and treatment for his behaviors.

A record review was completed for Resident D on 7/1/21 at 9:13 a.m. A facility census indicated the resident admitted to the facility on 5/4/21.

Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), generalized anxiety disorder (severe ongoing anxiety that interferes with daily activities), major depressive disorder (a mental disorder characterized by persistently depressed mood and long term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep and suicidal thoughts), and sleep disorder.

A physician/nurse practitioner note, dated 5/5/21 at 6:39 p.m., indicated, "Patient presented as to [local hospital name] on 4/28/21-5/4/21 for suicidal ideation, paranoia, depression without psychosis. Pt had been previously treated at [second local hospital name] for hyponatremia and was noted to have paranoid behaviors."

A communication note, dated 5/6/21 at 11:25 p.m., indicated the resident was at the nurses' station screaming racial slurs at the nursing staff and was redirected back to his room by a nurse. The resident indicated if his spouse or daughter did

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not come to pick him up, he wanted to hurt himself. The resident stated he did not have a plan and just wanted to get out of the facility and requested his medication to help him calm down. Nursing staff removed potentially harmful items from the resident's room and writer continued to talk to resident and reassure him. A snack and coffee were offered to the resident and he was placed on 15-minute checks. Resident was pleasant when followed up with by nursing staff.

A Situation, Background, Appearance, Review (SBAR) and Notify Communication Summary, dated 5/6/21 at 3:07 p.m., indicated there was a change in the resident's condition reported that consisted of behavioral symptoms. A mental status evaluation indicated the resident had increased confusion. A behavioral status evaluation indicated the resident had verbal aggression and other behavioral symptoms. A nursing observation, evaluation, and recommendation indicated the daughter had reported these types of behaviors had happened for the last 20 years. The primary care provider responded with a new order for Haldol (antipsychotic medication).

A communication with family form, dated 5/6/21 at 11:25 p.m., Resident D indicated if his spouse or daughter did not come to pick him up, he would hurt himself. Nursing staff removed potentially harmful items from his room. The resident's daughter indicated that the resident had been "this way for 20 years and is attention seeking." Resident D's daughter indicated that he had been calling her and stated he was going to "snap her neck" and calling her mother and telling her that she was "a lazy no-good wife."

A care plan, initiated on 5/6/21 and revised on

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	6/28/21, indicated the resident exhibited behavior symptoms of verbal aggression, threatening others, and using racial slurs. Per wife and family, resident would call on phone constantly day and night saying hateful things to them. Per family's request, room phone took out at this time. Interventions included, but were not limited to, approach resident in a calm friendly manner, document behaviors per behavior management program, assess residents needs for food, thirst, toileting needs, comfort level, body positioning, pain, maintain a safe environment for resident and treat as indicated. A care plan, initiated on 5/6/21, indicated the resident had behavior symptoms of delusions. Interventions included, but were not limited to, maintain a safe environment, and notify physician and psych services for increase in behavioral symptoms. A care plan, initiated on 5/7/21 and revised on 5/26/21, indicated the resident exhibited psychosocial well-being problem as evidenced by related to history of suicide ideation and suicide attempts. Interventions included, but were not limited to, 15-minute checks as needed and ensure a safe environment for resident. Remove any objects that the resident could use for self-harm such as call light cords, knives, sharp objects, blind strings, shoelaces. Resident would have plastic silverware, paper plates and a bell to use as a call light. A care plan, initiated on 5/7/21, indicated the resident had behavior symptoms of physical aggression, kicking doors, and throwing objects. Interventions included, but were not limited to, document behaviors per behavior management program, notify physician and psych services for			

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increases in behavioral symptoms and maintain a safe environment for resident.

A health status note, dated 5/7/21 at 4:25 p.m., indicated the resident was at the nurses' station throwing his arms in the air and stated if his daughter did not get there to pick him up, he was going to break the window. Resident threw items in his room breaking things and was kicking and swinging at staff. Resident was offered personal space, reassurance, and offered snack and drink which were not effective. An as needed (PRN) mediation was administered. The note lacked documentation of which PRN medication was administered and lacked documentation the family or physician had been notified.

A Medication Administration Record (MAR), dated May 2021, indicated Haldol solution 5 milligrams (mg)/ milliliter (ml), start dated 5/7/21 and discontinued on 5/8/21, inject 0.5 ml intramuscularly (IM) every 6 hours as needed for agitation. The MAR lacked documentation this medication had been administered.

A health status note, dated 5/7/21 at 8:28 p.m., indicated the resident broke a glass plate in his room and cut himself and the cut was superficial. The area was cleaned with normal saline and patted dry. Resident indicated he wanted to kill himself if he could not leave. Resident would be referred to psych services and was placed on 1:1 supervision.

A review of the resident's clinical record, dated 5/7/21, lacked documentation of an assessment and measurements of the resident's superficial cut to the neck.

A SBAR Communication Summary, dated 5/7/21,

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	indicated the resident was a danger to self or others, had suicide potential, and other behavioral changes. A health status note, dated 5/8/21 at 12:30 p.m., indicated the resident may be sent to for psychiatric evaluation and treatment. A psychiatric evaluation note, dated 5/9/21 from 8:50 a.m. to 9:50 a.m., indicated the resident had stated he was going to kill himself since he was not able to see his wife in the emergency department about a week ago. Behaviors started on 5/8/21 at a long-term care facility and resident was redirected with communication and food. Resident had verbal aggression, screaming, racial slurs and was redirected back to his room. The resident stated if had to stay there he would hurt himself and pointed to the call light and said he would use it. He was placed on 15-minute checks and ligature risks were removed. The resident had been yelling and was administered as needed Haldol, he flipped table and broke a clock on the wall and threw it. The intervention was communicated. The resident used broken glass to a glass plate and cut himself, unsure if it was intentional. The resident was placed on 1:1 supervision. A health status note, dated 5/8/21 at 1:41 p.m., indicated the resident remained on 1:1 care until transportation arrived. A health status note, dated 5/26/21 at 3:36 p.m., indicated Resident D was admitted to the facility via ambulance. Resident was alert to staff, had his call light in reach. Resident was assisted to bed with an assist of 2. Resident needed help with all his activities of daily living.			

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A social service note, dated 5/27/21 at 2:49 p.m., indicated the resident stated he was feeling a "little better" and had no plans to end his life. Resident would be placed on 15-minute checks. Room was searched for any objects that could be used for self-harm and none were found.

A MAR, dated May 2021, indicated 15-minute checks every shift. The MAR indicated this had been completed each shift from 5/27/21 through 5/31/21.

A 15- minute safety check off sheet, dated 5/27/21 through 5/28/21, indicated Registered Nurse (RN) 28 had signed off every 15 minutes from 5/27/21 at 2:45 p.m. through 5/28/21 at 2:15 p.m.

An employee timesheet, dated 5/27/21 through 5/28/21, indicated RN 28 clocked in at 2:34 p.m. on 5/27/21 and clocked out at 6:43 a.m. on 5/28/21. The timesheet lacked documentation she had worked from 6:44 a.m. to 2:15 p.m. during the times RN 28's initials were documented on the 15-minute safety check off sheet.

A physician/nurse practitioner note, dated 5/28/21 at 10:06 p.m., indicated "Hospital History [Patient] presented to [psych hospital] 5/8/21-5/26/21 for suicidal ideation, verbal aggression, screaming, racial slurs, and breaking a plate in an attempt to slit throat."

A MAR, dated June 2021, indicated 15-minute checks every shift. The MAR indicated this had been completed each shift from 6/1/21 through 6/30/21.

An Admission Minimum Data Set (MDS) Assessment, dated 6/1/21, indicated the resident was cognitively intact. The resident required

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physical assist of two plus staff.

A Psychiatry Initial Consult, dated 6/7/21, indicated resident was admitted to facility on 5/4/21 following an acute inpatient hospitalization and neruopsych hospital stay. " ...On 5/7/21 while eating his supper meal, patient broke a plate and attempted to cut his throat with the broken dish he was immediately sent back out to psych and returned to Majestic of Avon on 5/26/21 ...." Current risk factors indicated history of suicidal ideation, intent, plan, and recent attempt. The resident's mood was agitated, anxious, depressed, hopeless, overwhelmed, remorseful, tearful, tense. Assessment and plan for the resident indicated the resident's anxiety disorder was minimally stable and he was at increased risk of suicidal thinking.

A social service note, dated 6/10/21 at 5:07 p.m., indicated the resident stated if he could not leave the facility that he was going to kill himself. The resident did not have a plan. He was now on 15-minute checks. The room was searched, and no items were found the resident could use for self-harm. The note lacked documentation for any resident centered interventions being used. The note lacked documentation the family or physician had been notified at this time.

A health status note, dated 6/10/21 at 10:09 p.m., indicated the resident requested medication to help him sleep because he was able to calm down. The resident was currently on 15-minute checks for stating he wanted to kill himself earlier that afternoon. He was not receiving any scheduled sleep medications and did not have any as needed sleep medications. The nurse practitioner provided an order for trazodone (sedative), give 50 mg one time.

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A Psychology Diagnostic Assessment, dated 6/10/21, indicated, " ...Resident was recently returned from psychiatric hospitalization after he broke a plate and attempted to cut himself with it in an apparent suicide attempt or gesture (likely the latter since he did this in front of staff who intervened before he hurt himself) ...Resident was specifically angry about not having a phone installed in his room ...Resident also reported that he has struggled with depression since his teens, but has never been suicidal until coming to the facility. He also stated that his suicide attempt at facility was a 'mickey mouse act' because he wanted to get out of the facility ...He made several suicidal statements today ...Resident does not appear to have suicidal intent, but rather making threats and gestures for secondary gain purposes. However, unsafe behaviors such as this could result in injury. Resident only make suicidal statements in reference to getting out of the facility ...."

A health status note, dated 6/11/21 at 1:39 p.m., indicated the resident was attempting to remove a picture from the wall in the room. Resident was redirected but very anxious. Resident was offered medication to calm him, the resident stated the only thing that worked was Klonopin (antianxiety). A new order was obtained from the nurse practitioner. The note lacked documentation how the resident was redirected and if any other resident centered interventions were used prior to obtaining an order from the nurse practitioner.

A social service note, dated 6/15/21 at 9:34 a.m., indicated the note was a late entry and the resident had no further thoughts of suicide ideation. He no longer needed 15- minute checks.

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	A nursing skin assessment, dated 6/23/21, indicated the resident had no skin concerns. A health status note, dated 6/24/21 at 1:06 p.m., indicated the resident was verbally aggressive when he was told he could not go home. Attempted to schedule care plan with family but unsuccessful. The daughter requested the resident not call her or his spouse due to him being verbally abusive when he called. The resident wanted to review his chart and after reading a few items stated he was getting out of the facility that day and staff could not stop him. Resident then threatened and lunged at writer; other staff members attempted to redirect. After leaving room the resident threw his lunch tray against the wall and attempted to throw a chair in the room at the window. The nurse practitioner was called and new orders were obtained for a one-time dose of Haldol. Resident agreed to take the medication to calm him down. The note lacked documentation the family had been notified. The note lacked documentation any other resident centered interventions were used and failed to indicate what the staff done to try and redirect the resident. A MAR, dated June 2021, indicated Haldol solution 5 mg/ml, inject 1 ml IM one time only for agitation and aggression. The MAR indicated the medication had been administered on 6/24/21 at 1:30 p.m. A shower sheet, dated 6/26/21, indicated the resident had not skin concerns. A social service note, dated 6/28/21 at 12:55 p.m., indicated the resident's wife stated the resident would call on the phone constantly day and night stating hateful things to them. The family			

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requested the resident's telephone be taken out of his room to decrease the number of calls per day. The wife stated he could use the nurses' station phone a couple of times a day to call if needed. The writer spoke with maintenance to remove the phone and the resident's care plan was updated.

A health status note, dated 6/30/21 at 11:01 a.m., indicated the resident had a phone in his room in his drawer. The resident stated he had taken it from another room and the staff better not take it that he was not going to kill himself. Upon an assessment of the resident's skin the resident was observed to have four small puncture wounds within an area of discoloration. When the resident was asked what happened he indicated he stabbed himself with a fork and that it had happened when he was told he could not go home last week. No noted items present that could cause harm to resident except phone. The staff were instructed to check on resident every 15 minutes, the resident denied suicidal ideations. The nurse practitioner was notified.

A non-pressure ulcer note, dated 6/30/21 at 11:30 a.m., indicated the resident had an acquired area to the left lower abdomen. No drainage or odor noted. The area measured 9 centimeters (cm) length by 3 cm width by 0.1 cm depth and was yellow/purple in color. Skin was intact and open to air.

A social service note, dated 6/30/21 at 11:46 a.m., indicated the resident was having signs and symptoms of anxiety and verbal distress with staff and requested to speak with social services. The writer went and spoke with resident and he was upset about wanting a plan of care and where he was going from here. Writer explained to resident he was working with therapy services to get

"stronger," and his family wished for him to stay there at that time. Resident was able to recall having anxiety the night before and that day. Staff would continue to ensure resident was safe and writer would follow up and give support as needed.

A social service note, dated 6/30/21 at 3:20 p.m., indicated the resident had 1:1 care provided when he got out of bed and threw a bedside table towards the writer's stomach area and walked of the room and paced quickly to the font lobby area. Resident was easily redirected back to the nurses' station and was awaiting the paramedics arrival.

During an interview, on 6/30/21 at 3:55 p.m., Resident H's family member indicated the facility had notified her of an incident where they had to remove the resident's phone from his room because he had indicated he was going to strangle himself. He had been placed on 15-minute checks and this was the first incident she recalled being notified of.

During an interview, on 7/1/21 at 10:42 a.m., the DNS indicated she was unsure why the same nurse had documented 15-minute checks for a 24-hour period because staff do not work a 24-hour shift. The 15-minute checks were documented on paper, but a physician's order was also added where staff were documenting on the MAR every shift that 15-minute checks had been completed. She had determined the paper charting had discrepancies and that was why they switched to documenting it on the MAR. She was unaware prior to 6/30/21 that Resident D had stabbed himself with a fork. Once it was brought to her attention, she completed an investigation and found the resident had not reported it to staff that had cared for him. The resident was a set up

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	only for showers and CNAs would document and report to the nurse any new skin conditions they observed during a set up for a shower. A reportable was not completed for the incident of the resident breaking a plate and cutting his neck because it was looked at as a behavior and not a suicide attempt. The resident's phone had been removed from his room and he was able to take a phone out of another resident's room. The resident should not have had a phone in his room for safety reasons. Behaviors would be documented by nursing staff in the progress notes and CNAs would document in their daily charting. Any behaviors would be reported to the Social Services Director (SSD) and addressed at that point. During an interview, on 7/2/21 at 2:12 a.m., LPN 29 indicated he was unaware Resident D had previously attempted suicide or had been hospitalized for severe depression and suicidal ideation. That information could be found in care plans, but the staff had never seen it. He was unsure why they resident had not had a phone in his room and had assisted the resident to use the phone at the nurses' station. The resident had been on 15- minute checks but he was not sure why. The resident or other staff had not mentioned to him the resident had stabbed himself with a fork until this week when a manager brought up the concern. During an interview, on 7/2/21 at 2:12 a.m., RN 28 indicated Resident D was always restless, agitated, and often made threatening statements he would kill himself. The resident had things removed from his room that he could have used to harm himself. The resident was on 15- minute checks and staff would walk past the resident's room and make sure he was okay. They would not			

enter the room unless the resident needed something.

During an interview, on 7/1/21 at 5:50 p.m., the DNS indicated the resident was completely ambulatory and known for going into other resident rooms and that was how he was able to get a phone in his room and had done this before. He was known for doing that how were we supposed to keep someone like that safe.

During a telephone interview on 7/2/21 at 2:04 p.m., Psychiatrist 36 indicated he was aware of the two incidents with Resident D. He indicated the plate incident was an attempt to get out of the facility. This had been repetitive manipulative gestures of suicide to get what he wanted. He had never actually harmed himself where it required the resident to be hospitalized for injuries. He had very well-established manipulative gestures to get out of the facility. He was trying to manipulate the environment. In his opinion the resident was not "seriously suicidal." It was complicated with a depressed schizophrenic resident due to them being unpredictable. The probability of him intentionally harming himself was extremely low. What happens to these type of patients was they accidently harm themselves. They see that a lot with borderline suicide because gesture suicide by accident did happen. It would be accidental miscalculation not intention.

On 7/1/21 at 4:37 p.m., the DNS provided a document, revised on 6/1/18, and titled, "Accidents and Incidents - Investigating and Reporting," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy Statement: All accidents or incidents involving residents .... occurring on our premises shall be investigated and reported to the

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	Administrator ...2. The following data, as applicable shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; b. The nature of the injury ...c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The names of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs ...k. Any corrective action taken; l. Follow up instructions; m Other pertinent data as necessary or required ...." On 7/1/21 at 4:37 p.m., the DNS provided a document, revised on 6/1/18, and titled, "Dementia- Clinical Protocol," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Monitoring and follow-up: 1. The staff should monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician ...." The immediate jeopardy that began on 5/6/21 was removed on 7/2/21 when the facility assessed all residents for suicidal ideation and self-harm, all resident rooms were observed for hazards, and staff were in-serviced on behavior management for residents that voice suicidal ideation and/or self harm. The noncompliance remained at the lower scope and severity level of isolated no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued			

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monitoring.

B. During an interview, on 6/30/21 at 12:52 p.m., Resident H indicated one of the staff on night shift had grown tired of getting sodas and snacks for him from a secured vending area, so she provided him with the master code to get into secured door in the facility. At this time, Resident H went to a door with a sign that indicated biohazard on the door, attempted to open the door and the door did not open. The resident then put a code into the locked keypad and the door opened. The resident demonstrated this same activity with another door that had a sign that indicated janitor. There were unlocked electric panels observed in this secured room. The resident indicated he could not believe staff had provided him with the master door code and had went around at night and tried it on various doors, each time he had tried it on locked keypad door the door opened.

During an observation, on 6/30/21 at 3:19 p.m., the Interim Executive Director (ED) toured the facility with this surveyor. During the observation the Interim ED entered the master code into various keypads and was the same code Resident H had provided during an interview. The master code opened the following locked keypad doors: The Social Services office, the ED's office, the Minimum Data Set (MDS) office, the Director of Nursing Services (DNS) office, the Human Resources (HR) office, the kitchen, and the laundry room which included, but was not limited to cleaning supplies and the Janitor's office. The Janitor's office included 2 unlocked electric panels and a mechanical storage room that included unlocked electric panels and cleaning supplies. The cleaning supplies included, but were not limited to, a neutral quat disinfectant labeled with

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	hazardous ingredients, an array ultimate sanitizer labeled with hazardous ingredients, and a concentrated no-rinse floor cleaner labeled with hazardous ingredient. At this time, the Interim ED indicated residents should not have the master code to enter the secured rooms and should not have access to hazardous cleaning supplies. The staff should not have provided the master code to any resident regardless of the resident's cognitive status. During a record review, on 7/2/21 at 11:11 a.m., a safety data sheet for a neut ral quat disinfectant indicated the cleaner had hazardous ingredients that caused serious eye damage and skin irritation. A safety data sheet for an array ultimate sanitizer indicated the cleaner had hazardous ingredients that caused severe skin burns and serious eye damage. A safety data sheet for a concentrated no-rinse floor cleaner that indicated hazardous ingredients that caused serious eye damage. During an interview, on 6/30/21 at 1:20 p.m., Licensed Practical Nurse (LPN) 6 indicated residents should not have the master code to secured rooms. C. On 7/1/21 at 9:35 a.m., Certified Nurse Aide (CNA) 33 was observed as she walked out of a biohazard room. She did not wait to see if the door latched closed and locked behind her. On 7/1/21 at 9:40 a.m., the biohazard door in the MC area, on the 200 hall, was observed with a sign, it said, "Caution Biohazard Soiled Utility Authorized Personnel Only." The door had a			

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	code locking system. The door easily pushed open. Inside the room was a bottle of Restroom Disinfectant. It had spills down the sides and a small blue puddle under it. There was a large stainless-steel sink with a large amount of lime build-up and the faucet leaked. On 7/1/21 at 9:45 a.m., the biohazard door in the MC area, on the 300 hall, was observed with a sign, it said, "Caution Biohazard Soiled Utility Authorized Personnel Only." The door had a code locking system. The door easily pushed open. Inside the room was a stopped up, very dirty toilet-sink with a medium-sized circular item floating in brownish water. The sink had a large amount of lime build up.During an interview, on 7/1/21 at 10:02 a.m., CNA 34 indicated the biohazard rooms should always be locked up. If a resident got ahold of the Restroom Disinfectant, they could ingest it. During an interview, on 7/1/21 at 10:06 a.m., CNA 33 indicated the biohazard doors should all be locked. The Restroom Disinfectant should have been away from the residents because they could have gotten sick or poisoned. During an interview, on 7/1/21 at 10:15 a.m., the memory care Registered Nurse (MCRN) 20 indicated the census in memory care was 30, with 11 residents who wandered and 2 more residents who were exit seeking.During an interview, on 7/2/21			

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	at 11:55, the Maintenance Director (MM) indicated he provided the correct SDS information for Restroom Disinfectant and believed maybe a certified Nursing Aide (CNA) had held the biohazard door open for whatever reason and it did not lock. During an interview, on 7/2/21 at 10:10 a.m., the Interim Executive Director (IED) indicated the MC biohazard rooms should not have been unlocked. A Safety Data Sheet (SDS) for the Restroom Disinfectant was provided by the IED on 7/2/21 at 11:10 a.m. A review of the document indicated the Restroom Disinfectant was, " ...harmful if inhaled ...if swallowed: Rinse mouth. Do NOT induce vomiting ...immediately call a poison control center or physician ...corrosive (destruction by chemical reaction), harmful if swallowed ...Keep out of reach of children ...probable mucosal damage may contraindicated the use of gastric lavage (washing out of a body cavity) ...eye contact: pain, redness, swelling of the conjunctiva (coverings in front of eye and inside eye lids) and tissue damage ...skin contact: pain, redness, blistering and possible chemical burn ...ingestion (swallowing): damage or chemical burn to mouth, throat and stomach. Pain, nausea, vomiting and diarrhea ...hydrochloric acid (strong chemical substance)...acute health hazard ...."3.1-45(a)(1)3.1-45(a)(2)			

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to ensure the memory care (MC) medication cart was locked while unattended for 1 of 3 observations with the potential to effect 2 of 30 MC residents who wandered by it (Resident R and S) and the facility failed to ensure all medications in the main medication storage room had open dates and were not expired for 3 of 6 residents reviewed for open dates and expired medications (Resident D, H, and Q).	F 0761	Majestic Care of Avon respectfully request a desk review on or after 7/21/21. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. The memory care med cart was immediately locked. 2. Resident D's Pneumovax was	07/21/2021

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	Findings include: 1. On 7/1/21 at 9:30 a.m., the MC medication cart was observed unlocked with no staff within line of sight. Resident R and Resident S walked past the unlocked MC medication cart. Resident R walked past the unlocked MC medication cart on the side of the unlocked drawers. During an interview, on 7/1/21 at 9:35 a.m., MC Registered Nurse (MCRN) 20 indicated the MC Medication Cart should have been locked while unattended. During an interview, on 7/1/21 at 10:15 a.m., MCRN 20 indicated there were 30 residents who resided in the MC area, of whom 11 were wanderers (aimlessly walking) and 2 other residents were exit seeking. During an interview, on 7/1/21 at 3:42 p.m., MCRN 22 indicated the unlocked MC medication cart was a problem because MC residents take things, not only medications, but there were also scissors in the cart too. On 7/2/21 at 10:10 a.m., the Interim Executive Director (IED) indicated the MC medication cart should not have been unlocked without a nurse present. A current policy, titled. "Administering Medications," dated April 2019, was provided by the Regional Consultant on 7/1/21 at 3:04 p.m. A review of the policy indicated, " ...During administration of medications the medication cart is kept closed and locked when out of sight of the medication nurse or aide ...the cart must be clearly visible to the personnel administering		discarded and re-ordered on 7/2/21. 3. Resident H's Novolog was discarded and re-ordered on 7/2/21. 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 have potential to be affected by this alleged deficient practice. 1. RN #20 was immediately educated on keeping the medication cart locked. 2. All medication carts and medication rooms were audited on 7/21/21 to ensure all medications were properly dated and labeled. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 1. All licensed nurses were educated on proper dating and labeling of medications on 7/21/21 by the DNS/Designee. 2. All nursing staff were educated on ensuring that medication carts	

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	medications, and all outward sides must be inaccessible to resident or others passing by ...." 2. On 7/1/21 at 9:21 a.m., the main medication storage room was observed with Licensed Practical Nurse (LPN) 6. The findings were as follows: a. Resident D had an open Pneumovax 23 (pneumonia vaccine) for Injection 25/0.5. There was no open date. b. Resident H had an open Novolog (insulin for diabetes) 100 unit/mL (unit of measure). The physician's ordered indicated to give subcutaneously (under the skin) before meals per physician orders by sliding scale. There was no open date. c. Resident Q had an expired Firvanq Solution (antibiotic) 50 milligram (mg)/milliliter (mL). The physician ordered to give by mouth every other day. The label indicated it was open on 6/14/21 and expired 6/27/21. On 7/2/21 at 10:10 a.m., the IED indicated all medications should have correct labeling and no expired medications in the building. A current policy, titled, "Storage of Medications," dated 2020, was provided by Regional Consultant, on 7/1/21 at 3:04 p.m. A review of the policy indicated, " ...Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed...." 3.1-25(j) 3.1-25 (m)		remained locked at all times. 3. IDT will make rounds daily to ensure that medication carts remain locked. 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; Medication Storrage QAPI tool will be completed weekly X 4 weeks, monthly for 6 months and quarterly thereafter by the DNS/Designee. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be developed.	

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F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure the kitchen staff wore hair restraints while in the kitchen for 1 of 1 observation. Findings include: On 7/1/21 at 5:05 p.m., during a tour of the kitchen, staff were observed without hair restraints or a beard restraint. Dietary aide (DA) 30 and DA 31were not wearing hair nets. Cook 32 was not wearing a beard net. The surgical mask he was wearing did not cover all his beard. During an interview, on 7/1/21 at 5:10 p.m., the	F 0812	Majestic Care of Avon respectfully request a desk review on or after 7/21/21. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. Dietary Aide #30 and #31 immediately donned a hairnet. Dietary Aide #32 immediately donned a beard net.	07/21/2021

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	Certified Dietary Manager (CDM) indicated all the kitchen staff should have had their hair restrained. A policy, titled, "Infection Control," dated March 2019, was provided by the CDM on 7/1/21 at 5:16 p.m. A review of the policy indicated, " ...The Dietary manager will be responsible for overseeing the provision of safe food to all residents ...Hair will be restrained ...." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under "410 IAC 7-24-138: Effectiveness of hair restraint., Sec. 138.... (b) food employees shall wear hair restraints, ...that are designed and worn to effectively keep hair from contacting: (1) exposed food; (2) clean equipment, utensils...." 3.1-21(i)(2)		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 have potential to be affected by this alleged deficient practice. 1. Dietary Aides #30, 31, 32 were educated on proper usage of hair and beard nets on 7/2/21 by the Dietary Manager/Designee. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 1. The Dietary Manager/Designee will monitor to ensure all dietary staff appropriately wear hair and or beard nets. 2. All dietary staff were educated on proper hair/beard net usage on 7/21/21 by the Dietary Manager/Designee. 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;	

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			Hair/bear net usage will be monitored daily, at rotating times and shifts to include weekends. Corrective action will be implemented for any non-compliance. The QAPI committee will review monthly and if 100% compliance is not achieved an action plan will be	