DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	03/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00373486 and IN00372567. Complaint IN00373486 - Substantiated. Federal/State deficiencies related to the allegations are cited at F744. Complaint IN00372567- Unsubstantiated due to lack of evidence. Survey dates: March 7, 8, 9, 10, 11, 14 and 15, 2022. Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census Bed Type: SNF: 3 NF: 95 Total: 98 Census Payor Type: Medicare: 13 Medicaid: 57 Other: 28 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 23, 2022.	F 0000	The facility respectfully requests desk review	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility			

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	in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to assist a resident with eating in a sanitary and dignified way for 1 of 2 residents observed for assistance with eating (Resident 8). Findings include: During a continuous observation on 3/7/22 from 12:48 p.m. to 1:27 p.m., Resident 8 was observed seated in her wheelchair, at a memory care dining room table, with Certified Nursing Aide (CNA) 18. Resident 8 was observed to continually lean forward placing her head on either the table or on CNA 18's forearm. Prior to lunch, CNA 18 was breaking off pieces of a cookie with her bare hands. Using a bare hand, she pushed on Resident 8's upper chest until she was in a sitting-up position and placed a piece of cookie in Resident 8's mouth. After the cookie was placed in her mouth, Resident 8 laid her head on the table again. This happened several times until the cookie was gone. Once lunch arrived, CNA 18 was observed to use a fork to assist with eating. She pushed on Resident 8's forehead or chest to push her upper body backward into a sitting up position to get food into her mouth. Between bites of food Resident 8 would lean forward again with her head on the table or on CNA 18's forearm. During this process of Resident 8 leaning forward onto the table or on the CNA's forearm and being continually pushed back, CNA 18 touched her mask and adjusted her eyeglasses multiple times, propped her head on her hands, touched her hair, and rubbed Resident 8's back	F 0550	Majestic Care of Avon respectfully request a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident will be treated in a manner consistent with dignified and sanitary practices while dining 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 a. All residents have the potential to be affected by these practices. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. Education for staff completed on hand hygiene, residents rights and eating in a sanitary and dignified way. All staff will be in serviced by 4/4/22 4. 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. a. Dining room observation QAPI tool will be completed by DNS or designee 5 days a week x 1 month, 1 x weekly for 2 Months	04/04/2022

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	and her helmet. At no time, after touching her mask, eyeglasses, hair or propping her head on her hands or touching Resident 8's back or helmet did she hand sanitize or wash her hands. These events occurred until 1:27 p.m., when Resident 8 finished eating. On 3/7/22 at 1:27 p.m., CNA 18 indicated Resident 8 leaned forward during lunch because she was falling asleep, and she kept needing to wake her. On 3/14/22 at 8:34 a.m., the Minimum Data Set (MDS) Coordinator indicated the staff should not be feeding any resident with their bare hands, touching themselves and continue feeding the resident. A current policy, titled, "Assistance with Meals," dated July 2017, was provided by the DON, on 3/14/22 at 10:26 a.m. A review of this policy indicated, " ...Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity...." 3.1-3(a)		and Monthly x 4 Months until substantial compliance is obtained @ 90% or greater. Any negative trends will be reviewed and corrected.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, interview, and record review the facility failed to ensure fall care plans were updated with new interventions after a fall for 2 of 4 residents reviewed for fall care plan interventions (Resident 95 and 47). Findings include: 1. On 3/08/22 at 3:42 p.m., Resident 95's record was reviewed. Resident 95's diagnoses, include but were not limited to, dementia (progressive brain disorder), bipolar disorder with psychotic features (mental condition with alternating periods of elation and depression with a several mental disorder where contact is lost with reality), and generalized anxiety disorder. A nursing progress note, dated 12/18/2021 at 8:00 a.m., a late entry incident note indicated Resident 95 was found on the floor face down. His nursing assessment showed he had no bruises but had a swollen left hand and a blister on his	F 0657	Majestic Care of Avon respectfully request a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident who have a fall will have a care-plan updated with interventions 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 a. Residents who have a history of falls or who have fallen in the past have the potential to be affect by this practice. Those residents found affected were reviewed on 3/15/22 and corrected with	04/04/2022

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	left thumb. Resident 95 indicated he had no pain and could move all extremities. Vital signs were within normal limits. The nurse called the on-call provider. Neuro checks were started. A nursing communication with the provider, dated 12/18/2021 at 2:12 p.m., indicated a change in condition for Resident 95. The assessment showed he had a fall, was tired, weak, and confused with new pain. A nursing progress note, on 12/18/2021 at 6:33 p.m., Resident 95 was transferred to a local hospital via 911 for further treatment and evaluation due to a change in condition of lethargy, pale, weak, and yellowish skin color change. Vital signs were within normal limits. The medical doctor (MD) and Director of Nursing (DON) were notified. His family request he go out 911. On 12/21/2021 at 12:35 p.m., the Interdisciplinary Team (IDT) note indicated on 12/18/2021 Resident 95 was located on the floor in his room. The nurse did a full body assessment with the following findings, Resident 95's left hand appeared to be swollen. His vital signs were within normal limits. He was assisted off the floor. The nurse placed a call to the Nurse Practitioner, she gave the order to x-ray his hand. The family was notified, and they requested he be transfer to a local hospital. The Resident had a diagnosis of insomnia and general anxiety disorder. He had an unsteady gait due to poor safety awareness and impaired memory. The IDT risk intervention was to have the resident be evaluated for PT and OT upon return to the facility. The Minimum Data Set (MDS) information		updated care-plans and interventions. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. Care-plans will be updated as needed and per MDS schedule. Interventions were reviewed and updated by 4/4/22. IDT team educated on timely completion of Care-plans and interventions on 4/4/22. 4. 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. a. Care-plans will be monitored 5 days a week x 4 weeks, 1 x weekly for 2 months and monthly x 4 months or until substantial compliance is met @ 90% or greater. Any negative trends will be reviewed and corrected.	

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indicated Resident 95's discharged on 12/19/21 and returned to the facility on 12/27/21.

A nursing progress note, dated 12/27/2021 at 1:42 p.m., indicated Resident 95 returned from the hospital with a diagnosis of cellulitis. He was alert with some confusion. He had an entrance assessment with no additional findings.

Resident 95's fall care plan indicated he was at risk for fall related injury related to unsteady gait, medication use, poor safety awareness, impaired memory. The fall interventions were dated 9/8/21 and 1/7/22. There was no intervention for Resident 95's fall on 12/18/21.

During an interview, on 3/11/22 at 3:39 p.m., the DON indicated after Resident 95's fall there should have been a new intervention in his fall care plan.

During an interview, on 3/11/22 at 3:42 p.m., the MDS Coordinator indicated for Resident 95's fall care plan, a new intervention should have been for PT/OT (physical therapy/occupational therapy) to evaluate.

2. On 3/8/22 at 11:56 a.m., Resident 47's record was reviewed. Her diagnoses included, but were not limited to, non-traumatic brain dysfunction, dementia, and anxiety disorder.

A nursing progress note, dated 12/23/20, indicated Resident 47 was standing in her doorway to prevent a male resident from entering her room. The male resident was trying to get through her doorway and Resident 47 fell. She complained of right hip pain. Her vital signs were within normal limits. Resident 47 was not moved by the staff because of pain. 911 was called. The

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DON and family were notified. This fall was witness by staff.

An IDT note, dated 12/23/2020 at 9:10 p.m., indicated Resident 47 was standing at her doorway to not allow another resident to enter her room. The other resident was trying to get through doorway into room. Resident 47 fell. She complained of pain at her right hip and head. Her vital signs were within normal limits. Resident 47 was not moved by the staff because of pain, 911 was called. The DON and family were notified. The fall was witnessed by the staff. No intervention was documented by the IDT team.

A communication with the health care provider, on 12/23/2020 at 9:30 p.m., indicated the resident had a fall with uncontrolled pain. Her primary diagnosis was dementia with behavioral disturbance. The recommendation was to send her to the emergency room (ER).

A nursing note, on 12/28/2020 at 4:53 p.m., indicated Resident 47's three surgical incision dressings were intact with no sign or symptoms of infection at the surgical sites.

During an interview, on 3/14/22 at 12:45 p.m., the DON indicated the Memory Care (MC) nurse called her and indicated another resident bumped into Resident 47. He was trying to enter her room. She was standing with her walker. She left 911. The result was Resident 47 sustained a right hip fracture.

A fall care plan, dated 1/7/22, indicated Resident 47 was at risk for falls or fall related injury related to history of falls, likes to lay across bottom of bed with feet in her wheelchair,

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	psychotropic medication use, incontinence, poor safety awareness. She will get up out of wheelchair and self-ambulate down hallway, to her room, and to the dining room. The fall plan interventions were dated 3/11/2020, 11/29/2020, 11/9/21, 10/1/22, 2/1/22, and 2/1/22. There was no fall care plan intervention for her fall on 12/23/20. A current policy, titled, "Fall Management," dated October 2019, was provided by the DON on 3/14/22 at 10:26 a.m. A review of the policy indicated, " ...All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ...The care plan will be reviewed and updated, as necessary ...." 3.1-35(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on interview, and record review, the facility failed to ensure STAT (immediate) lab results were followed up on in a timely manner for a resident with a history of falls with injuries including fracture when she sustained a fall and complained of pain which resulted in delayed treatment of a hip fracture requiring surgical	F 0684	Majestic Care of Avon respectfully request a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	04/04/2022

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	repair for 1 of 7 residents reviewed for falls (Resident 97). Findings include: On 3/11/22 at 4:15 p.m., Resident 97's medical record was reviewed. A nursing progress note, dated 12/18/21 at 6:41 p.m., indicated Resident 97 was found lying on the floor on her back near her bathroom. During the head-to-toe assessment, Resident 97 complained of left hip pain and a STAT(immediate) x-ray was ordered. She was assisted back to bed and given Tylenol for pain management. A nursing progress note, dated 12/18/21 at 11:14 p.m., indicated Resident 97 remained in bed with no complaints of pain at that time. The STAT x-ray results were still pending. A nursing progress note, dated 12/19/21 at 5:50 a.m., indicated Resident 96 remained in bed. An additional PRN (as needed) dose of Tylenol was administered as Resident 97 "hollered out" in discomfort. The STAT x-ray results were still pending at that time. The record lacked documentation that the x-ray results were followed up on nor that a call had been placed to the contracted company who completed the x-ray to determine if the results were available. A nursing progress note, dated 12/19/21 at 10:45 p.m. (approximately 28 hours after the fall), indicated the x-ray result had been received and revealed a left hip fracture. Resident 97 was sent out 911 to the Emergency Department (ED).		a. The corrective actions will include timely follow-up of stat labs, that will prevent delay in treatment. Resident 97 was the resident affected. 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 who would need stat labs/X-rays have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. The facility has set up Positive text alerts for ADNS and DNS. Agency staff login will be placed at each nurses station by 4/4/22. All Clinical team members have been educated on where to access imaging and lab results on 4/4/22 4. 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. a. The DNS/ADNS will review monthly in QAPI to ensure imaging sms positive text alerts are being sent and followed up with in a timely manner.	

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During an interview on 3/14/22 at 2:35 p.m., Licensed Practical Nurse (LPN) 19 indicated she was the nurse on duty the evening Resident 97 fell. She completed the head-to-toe assessment and ordered the STAT x-ray. After the fall, Resident 97 was assisted back to bed and rested comfortably through the night. When LPN 19 returned to work the following evening, she checked on the x-ray results, but they were still unavailable. She continued onto her shift and completed medication administration and resident assessments. When she was done with medication administration, she checked a second time to see if the x-ray results had been received. The results were not at either nurses' station fax machine but had been sent to the administrative office fax machine. She found the results and arranged for Resident 97 to be sent immediately to the ED because of the hip fracture.

During an interview on 3/15/22 at 9:35 a.m., a Medical Records Representative (and former x-ray technician) for the contracted mobile x-ray company who completed the STAT lab indicated, their company received the STAT x-ray, completed and reported the x-ray results in "record time." However, no one from the mobile x-ray company called the facility to give report of the positive x-ray findings because the company could no longer afford to staff call centers to do so. Instead, the company had created a new electronic portal where the x-ray results had been uploaded.

During an interview on 3/15/22 at 9:38 a.m., the Director of Nursing (DON) indicated there was no set timeframe for STAT lab follow up, but that if the resident complained of pain, and the results were taking longer than usual, then the nurse

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	should call the DON to check on the results because she and the Administrator were the only staff with remote access to the electronic medical records. The DON indicated usually the lab called the facility to inform the nurse of any positive results, but if the lab did not call the facility, and it seemed to take longer than usual, then someone from the facility should have called and followed up with the company. A document titled, "Radiology Result Reports," was provided by the DON on 3/14/22 at 2:52 p.m., The report indicated the mobile x-ray was completed on 12/18/21 at 7:50 p.m. and reported on 12/18/21 at 8:53 p.m. Findings of the report revealed, "acute intertrochanteric left femoral fracture." A current facility policy titled, "Lab and Diagnostic Test Results- Clinical Protocol," dated 11/2018. The policy indicated, " ...the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requirements and arrange for test. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility ...nursing staff may sometimes determine that an individual's condition warrants immediate reporting of lab results ...." A copy of the contract between the facility and the contracted mobile x-ray company was provided by the DON on 3/15/22 at 10:45 a.m. The contract was titled, "[Name of Company] Care Portable Services Agreement," and dated 4/1/2021. The Contract agreement indicated, " ...provider shall provide prompt notice of any critical test results or findings as well as results from all STAT services. If Customer [the facility]			

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MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

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	chooses to receive Provider's results via fax, Customer shall be responsible for i) providing a designated confidential fax number for such results reported, ii) ensuring that the printer or fax machine is checked often enough for the presence of printed reports, and iii) that the printer or fax machine is in working order. When results are faxed or printed, Customer understands that Provider has no means of indicating on the report the name of the person receiving the fax or printed report at the Customer. Similarly, Provider shall not be responsible for faxed or printed reports not being properly received, printed, or retrieved by the Customer ...." 3.1-17(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to prevent an injury of unknown origin for a dementia resident with a language barrier and requiring assistance with transfers and activities of daily living when a resident with an uncontrolled nosebleed was sent to the hospital and found to have bilateral nasal bone fractures with uncontrolled bleeding into the sinus cavity, subdural hematoma (head bleed), gastrointestinal bleed, multiple areas of bruising, and a left arm DVT (deep vein thrombosis, clot) for 1 of 5 residents reviewed for dementia care (Resident B).	F 0744	Majestic Care of Avon Respectfully requests a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident B no longer resides in the facility. 2. How other residents having the potential to be affected by the same deficient practice will be	04/04/2022

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	Findings include: On 3/13/22 at 10:00 a.m., the closed medical record was reviewed for Resident B. The diagnoses included, but were not limited to dementia, diabetes and immune thrombocytopenic purpura (bleeding disorder). The resident had no documented falls in the past 6 months reviewed. She did not speak English. An activities of daily living care plan, created 1/7/20 and current as of 3/13/22, indicated Resident B needed assistance with related to dementia. The goal was for Resident B's care needs to be met daily with assistance of staff. Interventions included but were not limited to assist with incontinent care, staff assistance with bed mobility, staff assistance with eating, staff assistance with personal hygiene, assistive device of a wheelchair, staff assistance with toilet use, and staff assistance with transfer. A care plan, dated 1/7/20, indicated Resident B needed assistance with activities of daily living and had impaired physical mobility related to chronic displacement of her left shoulder. The goal was for Resident B will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury. Interventions included but were not limited to observe for complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury. A care plan, dated 5/11/21, indicated Resident B spoke Hindi and required use of nonverbal/tactile/visual cues. She was able to follow simple commands and answer yes and no		identified and what corrective action(s) will be taken a. All residents who are non english speaking have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. All staff have been educated on use of boost-lingo interpretation service. The facility will screen all residents that are non english speaking for appropriate care plans interventions and identify those who would benefit from interpretation service. Care plans and interventions updated by 4/4/22. All staff will be educated on facility abuse policy upon hire, annually and reeducated by 4/4/22. 4. 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. a. The facility will screen all non english speaking new admissions for appropriate care plan and intervention. Monthly x 4 months the facility will review all new admits to ensure quality outcome of those who do not have english as the primary language. Substantial compliance @ 90%. Any negative trends will be reviewed and corrected.	

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to simple questions. Translator apps worked well on phones and computers as well.

A care plan, dated 5/11/21, indicated Resident B was at risk for falls or fall related injury related to decreased mobility and medication and incontinence. Interventions included but were not limited to encourage and assist to wear appropriate nonskid footwear, assist with toileting, assist with transfers.

On 2/1/22 at 4:36 a.m., a health status note indicated, "Writer was notified by CNA [Certified Nursing Assistant] that resident was noted to have a nose bleed ...upon assessment resident was holding her nose as it bled. This writer applied a cold compress to the residents nose for about 15 minutes. Bleeding subsided upon removal of compress. 0 other distress noted. Resident nose was packed on one [sic] with gauze. Will continue to monitor for any further bleeding. VS [vital signs] was within normal limits for resident. 131/68, 72, 18, 97.9."

On 2/1/22 at 8:23 a.m., a health status note indicated the resident was sent to the local hospital due to nosebleed that would not stop bleeding. The Nurse Practitioner (NP) and the family was made aware.

On 2/3/22 at 7:36 p.m., a health status note indicated, "Called [Name of Trauma Hospital] to get updates on resident. Nurse stated she could not give me any updates at this time but that resident was in ICU [intensive care unit]."

A hospital report with an admission date of 2/1/22, indicated an Arabic speaking resident was transferred as a Trauma II from another local hospital for a subdural hematoma (SDH, head

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	bleed). Resident stated she was struck multiple times "everywhere" including abdomen and face by a male at her house yesterday. The resident was originally transferred from the nursing facility to the local hospital for an uncontrollable nosebleed. Resident was interviewed with assistance of a video interpreter, and the son. Bruising, in various stages were noted around her left eye, nose, forehead, and checks extending to the ear. There were multiple areas of purple and blue ecchymosis (bruising) on left shoulder, left humorous (arm) and left forearm. Resident was in significant pain. The resident's son had indicated to the physician, the resident had bruises at the facility prior to the incident. The facility told him she sometimes fell when transferring into her wheelchair. The resident had dementia and was confused. The diagnoses were listed as bilateral nasal bone fractures with uncontrolled bleeding into the sinus cavity, SDH (subdural hematoma) due to a "physical assault" at the nursing facility. Upon admission, the resident had a decrease in HgB (hemoglobin, blood count) from 6.7 to 5.7 and was transfused with 2 units PRBC (packed red blood cells) and was also given 2 units of plasma. There was blood present in her stool. A consult was called for a GI (gastrointestinal bleed) and endoscopy. There was a DVT (clot) in the left arm. On 3/10/22 at 10:28 a.m., during an interview with the Assistant Director of Nursing (ADON) and the Nurse Supervisor. They indicated neither of them were working in the Memory Care Unit on the day of Resident B's incident. They believed it was an agency nightshift nurse. The Nurse Supervisor had gotten a phone call that Resident B had a nosebleed. She had a history of			

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a low platelet count which could cause bleeding. The DON came into the building and assessed the resident. Then 911 was called to send her to the local hospital. The resident did not speak English, so they were unaware of her allegation that she was hit by someone and knocked down. When the staff was made aware of the nosebleed the resident had rolled out of her room, in her wheelchair with her hands cupped below her face and blood coming from her nose.

On 3/10/22 at 10:38 a.m., during an interview the Director of Nursing (DON) indicated the staff had lightly put a piece of gauze into the nose, not really packed it in. Then when EMS (emergency medical services) arrived they put a tampon in the resident's nose. The DON provided a copy of the investigation report, and file of the facility's investigation for review. The report indicated on 2/4/22 the resident's son had made the facility aware of the resident's allegations that she had been assaulted by someone in the facility. A state reportable was filed to the IDOH at that time. Interviews were conducted of all the Memory Care residents and staff members. The facility investigation was unable to substantiate the resident's claim of assault in the facility.

The Hendricks County Police report, dated 2/6/22 at 4:19 p.m., indicated dispatched to location for possible battery report. "I spoke with (Name of Resident B) who stated that on 1/31/22 a black male nurse of hers came in the room and struck her in the face. I then spoke with (Name of DON) who is in charge of the nursing staff and she stated (Resident Name) was transported because her nose would not stop bleeding. She stated the [sic] was bleeding for two days. (Name of DON) stated that there was no trauma to the face and that (Name of Resident) has a blood

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	disease and prevents clotting. (Name of Resident) suffers from serve [sic] dementia. There were only female nurses working the night she said she was struck. There are no charges in this case." On 3/10/22 at 3:01 p.m., during an interview, the Nurse Supervisor indicated an employee (Name), was suspended during the investigation. Then was allowed to return to work after investigation was completed, and still worked at the facility. The employee had worked evening shift the night before, but not on the night shift when the resident's nosebleed had started. That employee was not in the building when the resident came from her room with her nose bleeding. The resident's room had blood on the door handle and the side of the bed. There was no indication she had fallen, and she had not had any recent falls. The staff thought it was a spontaneous nosebleed. The facility followed the State Rules for investigating and reporting an injury of unknown origin once it had been determined as a possible trauma. They were unable to identify the cause. The resident never returned to the facility. On 3/9/22 at 9:00 a.m., the Administrator provided a current policy, dated as revised March 2021, titled, "Abuse Prevention Program." This policy indicated, "Our facility is committed to protecting our residents from abuse by anyone, including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to our residents, family members, resident representative, legal guardians, surrogates, sponsors, friends, visitors, or any other individual...When an alleged or suspected (reasonable cause) case of mistreatment, neglect, or exploitation, injuries of unknown			

source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury, no later than 2 hours if the event is an allegation of abuse or where there is significant injury, or neglect where there is bodily injury) notify the following persons or agencies of such incident...Injury of unknown source is defined as an injury that meets both of the following conditions: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of: the extent of the injury; or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time... "

This Federal tag relates to Complaint IN00373486.

3.1-37(a)

F 0755
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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 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

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	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 narcotic medications were signed out and reconciled in the narcotic book for 3 of 3 residents during medication administration (Resident 21, 96, and 43). Findings include: During a continuous medication administration observation with Registered Nurse (RN) 14, from 11:48 a.m. to 1:06 p.m., it was noted three residents received narcotics and the nurse did not sign them out in the narcotic book or reconcile the narcotics. On 3/11/22 at 11:53 a.m., Resident 21 received one Percocet (pain reliever) 10/325 mg tablet.	F 0755	Majestic Care of Avon respectfully requests a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. No residents were affected. The facility aims to ensure clinical team members are signing out narcotics. 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 a. All residents that receive narcotic medication have the	04/04/2022

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	On 3/11/22 at 12:14 p.m., Resident 96 received one Klonopin (treats seizure and panic attacks) 0.5 mg tablet. On 3/11/22 at 12:47 p.m., Resident 43 received on Perocet 10.325 mg tablet. During an interview, on 3/11/22 at 1:13 p.m., RN 14 indicated she should have signed out (documented) the narcotic medications in the narcotic book as soon as she gave them to each resident to be sure the medication amounts were reconciled for each narcotic. During an interview, on 3/11/22 at 1:19 p.m., RN 14 indicated the narcotic reconciliation was incomplete for the narcotics dispensed for Resident 21, 96, and 43. On 3/11/22 at 1:28 p.m., RN 14 indicated upon narcotic reconciliation completion, the narcotics amounts were found to be accurate. During an interview, on 3/11/22 at 2:30 p.m., the Regional Nurse Consultant indicated the facility did not have a specific narcotic policy, but used the medication administration policy. A current policy, titled, "Administering Medications," dated April 2019, was provided by the Director of Nursing (DON), on 3/11/22 and 3:40 p.m. A review of the document indicated, " ...medications are administered in a safe and timely manner, and as prescribed ...." 3.1-25(b)(3) 3.1-25(e)(2)		potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. All staff will be educated by 4/4/22 on signing out narcotics in the narcotics book to be sure the medication amounts are reconciled. 4. 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. a. Medication pass QAPI tool will be completed by DNS or Designee 5 days weekly x 4 weeks. Weekly x 2 months and monthly x4 months or until substantial compliance of 90% or greater. All negative trends will be reviewed and corrected.	

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F 0809 SS=D Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.			
	Based on observation, interview, and record review, the facility failed to follow standards of practice for offering protein snacks to aid in the management of insulin dependent diabetics, on the Memory Care unit for 3 of 3 insulin dependent residents reviewed for dementia care (Residents C, 97, and 60). Findings include: On 3/10/22 at 9:47 p.m., during a random observation, on the Memory Care Unit, Resident C was standing at the nurses' station counter speaking in Spanish to Qualified Medication Aid (QMA) 12. QMA 12 indicated she did not know	F 0809	Majestic Care of Avon respectfully requests a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Evening snacks that align with diabetic management practices will be offered. 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	04/04/2022

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	that language and instructed Resident C to speak English. She asked him if he wanted some water or a snack. The Resident continued speaking in Spanish. QMA 12 went to the pantry and brought back 5 individually wrapped snack cakes and gave them to the resident. She then gave him a cup of water. Resident C remained at the nurses' station, where he continued to speak to staff in Spanish as he consumed all 5 snack cakes. QMA 12 gave him a second cup of water. On 3/10/22 at 10:01 p.m., during an interview, QMA 12 indicated she didn't know exactly what language Resident C had been speaking, he could speak English at times, when he wanted to. They encouraged him to speak English. She didn't have any way to communicate with him in his language. That was why she had tried to get him to speak to her in English. On 3/10/22 at 10:03 p.m., QMA 12 told Patient Care Assistant (PCA) 13 to make sure Resident 97 got a bedtime snack. PCA 13 went to the pantry and took some snack cakes down the hall to Resident 97's room. On 3/10/22 at 10:05 p.m., during an interview, PCA 13 indicated they did not have any other kinds or snacks for residents. They did not have any kind of protein, fruits, or sandwiches. On 3/10/22 at 10:08 p.m., the Infection Preventionist (IP) asked QMA 12 had Resident C had his blood sugar checked. QMA 12 indicated she had checked it earlier, before she gave him a snack, so it was OK. On 3/10/22 at 10:09 p.m., during an observation and interview, the Memory Care Unit's pantry was observed with the Infection Preventionist		a. All residents that are diabetic have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. The Dietary Manager or designee will offer protein snacks in the evening. Staff have be educated on protein snacks located in refrigerator 4. 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. a. The Memory Care Facilitator and designee will monitor Refrigerator ensuring appropriate items are available in the evenings daily 5 days x 4 weeks. Weekly x 2 months and monthly x 4 months or until substantial compliance is achieved. All negative trends will be reviewed and corrected.	

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	(IP). There were two large containers on the counter. One contained individually wrapped snack cakes and the other contained individual bags of Goldfish Cheddar Crackers. The cabinets contained at least a dozen boxes filled with snack cakes. The IP indicated there was usually bread and peanut butter available in the cabinets if diabetics needed something, there was none. The refrigerator contained some pudding cups, canned soda pop and 3 apples. The refrigerator's freezer had some individual fruit ice cups/sorbet and ice cream. The IP indicated Resident C was diabetic and his blood sugar had already been checked before he was given the snack cakes. On 3/14/22 at 2:28 p.m., during an interview, the Dietician provided a list of diabetic residents in the facility and a list of residents who received special diets. There were 37 residents with a diabetic diagnosis and 4 of those residents received a carbohydrate-controlled diet. One resident, on the Memory Care Unit (Resident D), received a consistent carb diet. One resident on Memory Care (Resident 97) had an order for a bedtime snack. She indicated most of the diabetic residents were on a regular diet. They were treated more liberal (now). Residents were allowed to choose if they wanted to eat higher carb foods. It was their choice, even if they had impaired cognition (Memory Care residents). Resident C was on a regular diet he could choose what he wanted to eat, even if he had dementia and didn't choose a healthy snack that was his choice and they tended to give him snacks throughout the day to manage his behaviors. If he wanted sugary snacks that was his choice. "He should be given options. He can indicate yes or no." The kitchen maintained the unit pantries, there should have been protein options in the kitchen as well as milk and juice. The kitchen did			

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	not send out a specific snack to diabetics, unless there was a specific doctor's order to do so. Bedtime snacks were offered to all residents. At that time, she provided, 2 postings from the kitchen, a list of snacks which were supposed to be stocked in the unit pantries, and a posting that indicated stocking of pantries was done every Friday, during clean-up. This posting/list, titled "Snacks" indicated a variety of cookies, a variety of crackers, P & J (peanut butter and jelly) sandwiches, deli sandwiches (on request), granola bars, chips, oranges, apples, bananas, sugar free pink lemonade, lemonade, punch, milk (2%, whole, chocolate and skim), yogurt, cottage cheese, ice cream, sherbet, and a variety of juice. On 3/11/22 at 3:21 p.m., the IP provided resident grievance forms for the past 6 months, for review. On 9/22/21 at 3:00 p.m., the Social Service Director (SSD) had spoken to a (now former) resident (Confidential Name), related to the resident's concerns. The grievance report indicated the resident was asking for certain foods, PBJ, yogurt, and fruit. She had indicated she had not been receiving insulin and food on time which caused her diabetes to "go crazy" and stomach upset with increased diarrhea. The Department Head review indicated the Unit Manager "fixed the orders for diabetes." 1. On 3/14/22 at 9:30 a.m., the medical record was reviewed for Resident C. The diagnoses included, but were not limited to, dementia with behavioral disturbance and diabetes type 2. The physician's orders indicated a regular diet, no restrictions. Humulin R (regular- fast acting) insulin sliding scale (amount designated based on blood sugar result), glargine insulin (long acting) 40 units at bedtime.			

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Resident 82 resided on the Memory Care Unit.

The March Medication Administration Record (MAR) indicated Resident C received blood sugar checks before meals and at bedtime. Sliding scale coverage was given based on the result (range 151-400). The MAR indicated Resident C received sliding scale insulin 38 out of 53 times for blood sugars greater than 151. His blood sugars ranged from 89 to 359.

2. On 3/14/22 at 10:15 a.m., the medical record was reviewed for Resident 97. The diagnoses included, but were not limited to, diabetes type 2 and dementia. The physician's orders indicated encourage a HS (hour of sleep) snack at bedtime to prevent hypoglycemia (low blood sugar). No restriction diet. Humalog insulin (fast acting) with meals, inject 13 units. Notify MD (medical doctor) for blood sugars less than 70 or greater than 300. Humalog (fast acting insulin) per sliding scale insulin (151-350). Glargine insulin (long acting) 22 units two times a day.

Resident 97 resided on the Memory Care Unit.

The March Medication Administration Record (MAR) indicated Resident 97 received blood sugar checks before meals and at bedtime. Sliding scale coverage was given based on the result (range 151-350). The MAR indicated Resident 97 received sliding scale insulin 39 out 54 times for blood sugars 151 or greater. Resident 97's blood sugars ranged from 86- 384.

3. On 3/14/22 at 11:00 a.m., the medical record was reviewed for Resident 60. The diagnoses included, but were not limited to diabetes type 2, dementia with behavioral disturbances and psychotic disorder. The physician's orders

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included a no restriction diet, and Lantus (long-acting insulin) 30 units at bedtime.

Resident 60 resided on the Memory Care Unit.

The March Medication Administration Record (MAR) indicated Resident 60 received blood sugar checks before meals and at bedtime. The record indicated Resident 60 had refused her bedtime long-acting insulin 11 out of 13 times. She often refused blood sugar checks also. The record indicated she had blood sugars of 346, 500, 600, 477, 207, 591, 547, 152, and 155. The resident had call orders for below 70 or greater than 350. No was marked on 4 results for calling the doctor, and yes was marked on 4 results.

On 3/14/22 at 1:30 p.m., during an interview the IP indicated the resident often refused her insulin at bedtime. The doctor was aware. Her blood sugars were high when checked because she refused her insulin. The nurses marked Y (yes) or N (no) on the MAR to indicate if they called the doctor. If there were any additional orders at that time, they would have been in the physician's order set (there were none). They did not make a progress note if they talked to the doctor. The conversation was not documented anywhere. The physician's routine visit notes indicated he was aware of her frequent refusals.

On 3/11/22 at 12:25 p.m., during a random lunch observation on the Memory Care Unit one meal tray was prepared for a Consist Carbohydrate diet, for Resident D. The meal consisted of spaghetti and meat balls, Italian green beans, garlic French bread, parmesan cheese, lemon pudding and whole milk. Licensed Practical Nurse (LPN) 21 prepared additional drinks for the tray. She placed coffee and fruit punch on the

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	tray. The meal tray card indicated "Reg Consistency CHO." LPN 21 took the tray down the hall to Resident D's room. During an interview, at that time she indicated the lemon pudding was not sugar free and the fruit punch, prepared by the kitchen, also contained sugar. She pointed to the meal card and said it was for a regular consistency diet. She did not know what CHO meant. The tray was served to the (new admission) resident in her room. On 3/14/22 at 10:26 a.m., the Regional Nurse Consultant (RNC) provided a copy of the "Consistent CHO" menu for March 8 through March 12. The lunch menu on March 11 was the same as the regular diet menu except a notation for sugar substitute to be offered with coffee or tea. On 3/11/22 at 10:30 a.m., the Dietician provided a current policy, dated October 2018, titled "Bedtime or H.S. Snacks." This policy indicated, "All residents will be offered a snack around the bedtime hour...The Nutrition Department will deliver snacks to each nursing station or pantry before closing for the evening...Bedtime/HS Snacks are pre-planned and posted in the Nutrition Department may include but not be limited to cookies, crackers, fruit, milk and low-calorie beverages. Acceptance or refusal of Bedtime/HS snacks will be recorded in the EMR (electronic medical record)." On 3/11/22 at 10:30 a.m., the Dietician provided a current policy, dated as revised November 2020, titled "Diabetes- Clinical Protocol." This policy indicated "...Resident preferences should be taken into account; for example, if someone who understands the risks chooses...the primary or sole use of sliding scale insulin is not a			

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	preferred way to handle diabetes over the long term...the idea of "diabetic diet" is outdated and dietary restrictions may be liberalized in most patients...Where insulin is indicated, simplified treatment regimens are preferred, using long acting insulin...An example of appropriate treatment of hypoglycemia for a responsive individual would be 15 g to 20 g of carbohydrate in the form of glucose, sucrose tablets, or juice, combined with a sandwich, crackers, or other light snack containing protein..." 1.3-21(f)(2)			
F 0812 SS=E 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	F 0812	Majestic Care of Avon respectfully	04/04/2022

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	review, the facility failed to ensure the kitchen had all food products dated with open and expiration dates and the freezers had internal thermometers for 1 of 2 observations of the kitchen, and the cooks had their facial hair covered for 2 of 2 observations of the kitchen. The facility failed to assist a resident with eating in a sanitary and dignified way for 1 of 2 residents observed for assistance with eating (Resident 8). Findings include: 1. On 3/7/22 at 9:14 a.m., the Culinary Area Manager provided a kitchen tour. Food items with no open or expiration dates were as follows: a. Three large bottles of lemon juice. b. A container of garlic in water. c. Two containers of beef base. d. A package of previously opened ham. e. A small package of previously opened turkey. f. A previously opened Tiramisu cake, partially served. g. A plastic container of tomatoes. h. A plastic container of cucumber. i. A opened and rolled down plastic bag of chips. j. An opened package of hot dog buns. A current policy, titled, "Labeling and Dating," dated October 2018, provided by the DON, on 3/14/22 at 10:26 a.m. A review of this policy indicated, " ...Any ready-to-eat food or prepared food will be labeled with the date opened or prepared on and the date of discard ...." A standalone freezer had no thermometer, and the walk-in freezer had no thermometer. On 3/14/22 at 12:01 p.m., the Regional Nurse Consultant indicated thermometers were added		requests a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Food Items will be labeled with open dates, Dietary Refrigerator will have thermometer added and staff with facial hair will wear beard nets. 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. 1. All residents who eat out of the facility dietary kitchen have the potential to be affected by this practice. 1. 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 department staff have been educated on Proper use of Beard nets, Labeling and dating and Thermometers placed in the refrigerator 1. 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. 1. The Director or designee will monitor Beard net/Labeling and dating compliance 5 days a week x 4 weeks, weekly x 2 months and monthly x 4 months.Thermometer will be monitored weekly x 2	

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	to the freezers the and the temperature logs were completed. A current policy, titled, "Equipment Temperature Monitoring," dated October 2018, was provided by the DON, on 3/14/22 at 10:26 a.m. A review of this policy indicated, " ...Each refrigerator/freezer unit will have an internal thermometer ...." On 3/07/22 at 9:49 a.m., Cook 17 was wearing a surgical mask but it did not cover the sides of his beard. He indicated he should have been wearing a beard cover. On 3/15/22 at 11:10 a.m., Cook 24 was wearing a surgical mask but it did not cover the length of his goatee. The bottom hair of his goatee was exposed. He indicated he should have been wearing a beard cover and immediately put one on. During an interview, on 3/15/22 at 11:06 a.m., the Culinary Area Manager indicated the staff should have been labeling and dating foods with an open date, a date it was prepared, and a use by date. The freezers should have thermometers inside them and all male staff with facial hair should have been wearing beard covers. A current policy, titled, "Food Safety and Sanitation," dated March 2019, was provided by the DON, on 3/14/22 at 10:26 a.m. A review of this policy indicated, " ...Hair will be restrained ...." 2. During a continuous observation on 3/7/22 from 12:48 p.m. to 1:27 p.m., Resident 8 was observed seated in her wheelchair, at a memory care dining room table, with Certified Nursing		months and monthly x 4 months. The facility will review all items in our monthly QAPI until substantial compliance is achieved @ 90% or greater. Any negative trends will be reviewed and corrected.	

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Aide (CNA) 18. Resident 8 was observed to continually lean forward placing her head on either the table or on CNA 18's forearm. Prior to lunch, CNA 18 was breaking off pieces of a cookie with her bare hands. Using a bare hand, she pushed on Resident 8's upper chest until she was in a sitting-up position and placed a piece of cookie in Resident 8's mouth. After the cookie was placed in her mouth, Resident 8 laid her head on the table again. This happened several times until the cookie was gone.
Once lunch arrived, CNA 18 was observed to use a fork to assist with eating. She pushed on Resident 8's forehead or chest to push her upper body backward into a sitting up position to get food into her mouth. Between bites of food Resident 8 would lean forward again with her head on the table or on CNA 18's forearm. During this process of Resident 8 leaning forward onto the table or on the CNA's forearm and being continually pushed back, CNA 18 touched her mask and adjusted her eyeglasses multiple times, propped her head on her hands, touched her hair, and rubbed Resident 8's back and her helmet. At no time, after touching her mask, eyeglasses, hair or propping her head on her hands or touching Resident 8's back or helmet did she hand sanitize or wash her hands. These events occurred until 1:27 p.m., when Resident 8 finished eating.

On 3/7/22 at 1:27 p.m., CNA 18 indicated Resident 8 leaned forward during lunch because she was falling asleep, and she kept needing to wake her.

On 3/14/22 at 8:34 a.m., the Minimum Data Set (MDS) Coordinator indicated the staff should not be feeding any resident with their bare hands, touching themselves and continue feeding the

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	resident. A current policy, titled, "Assistance with Meals," dated July 2017, was provided by the DON, on 3/14/22 at 10:26 a.m. A review of this policy indicated, " ...Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity ...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure a shared glucometer (equipment to check a resident's blood sugar level) was cleaned according to policy and manufacturer's recommendations for 3 of 8 residents reviewed for use of a shared glucometer (Resident 21, 31, and 81). Findings include: On 3/11/22 at 8:24 a.m., Registered Nurse (RN) 14 entered Resident 31's room to check her glucose level, she did not have breakfast yet. Resident 31 asked RN 14 not to do the finger stick on the tip of her finger. RN 14 indicated we always do it on the tip of your finger. Resident 31 closed her eyes, and slowly nodded. RN 14 did not wear gloves, stuck Resident 31 on her fingertip, and acquired the necessary blood to get the blood sugar level. Once in front of the medication cart, she placed the soiled glucometer directly on top of the medication cart. She asked someone to bring her bleach wipes. They brought her Micro-Kill Bleach wipes. She wiped the glucometer for 2 minutes and placed it on a clean paper towel to dry. She fanned the glucometer so it would dry faster. She did not clean the top of the medication cart. On 3/11/22 at 8:41 a.m., RN 14 picked up the glucometer from the paper towel and placed it in the soiled glucometer supply bin. Resident 81 had not started her breakfast yet, but indicated she already drank her Ensure (nutritional supplement). RN 14 did not wear gloves to check her blood sugar. After Resident 81's blood sugar	F 0880	Majestic Care of Avon respectfully requests a desk review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Proper sanitation of glucometer. 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 a. All residents that are diabetic have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. Education provided to the nursing team members on proper procedure on completing accuchecks and cleaning glucometer to help prevent the spread of communicable diseases and infection. 4. 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. a. The DNS or designee will observe cleaning of glucometer daily for 6 weeks. Data will be reviewed in QAPI and monitored	04/04/2022

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	check was completed, RN 14 wiped the glucometer for 5 seconds and then partially wrapped it in the Micro-Kill bleach wipe and laid it on the same paper towel for 1 ½ minutes. The paper towel was wet when she picked up the glucometer and placed it in the soiled glucometer supply bin. On 03/11/22 at 8:56 a.m., Resident 21's blood sugar was checked after he finished his breakfast. RN 14 did not wear gloves to check his blood sugar. After Resident 21's blood sugar was completed, RN 14 placed the soiled glucometer on top of the medication cart. She picked up the glucometer, did not wipe it, and wrapped it in the Micro-Kill bleach wipe. She did not wipe the top of the medication cart. She left the glucometer wrapped in the bleach wipe for 3 minutes. During an interview, on 3/14/22 at 8:35 a.m., the Minimum Data Set Coordinator (MDS) indicated staff should have been cleaning the shared resident glucometer according to policy. During an interview, on 3/14/22 at 11:52 a.m., the Infection Preventionist (IP) indicated to clean the glucometer, it took 3 minutes, not 3 minutes of friction, but 3 minutes being wet. It took 3 minutes to allow it to dry after it has been wiped thoroughly. On 3/15/22 at the exit conference the management team provided a list of 8 residents that utilized the shared glucometer for the unit. A document specific for cleaning the glucometer from the manufacturer titled, "Cleaning and Disinfecting Procedures for the Meter," with no date, was provided by the Director of Nursing (DON), on 3/14/22 at 10:26 a.m. A review of		until substantial compliance is achieved @ 90% or greater. Any negative trends will be reviewed and corrected.	

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	this document, indicated, " ...The meter must be disinfected between patient used by wiping it with ...EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The Disinfection process reduces the risk of transmitting infectious disease if it is performed properly...Cleaning Instructions...Wash hands with soap and water, put on single-use gloves. Wipe the glucose meter thoroughly including the front, back and side. Do not wrap the meter in a wipe...Disinfection Instruction...." A document specific for cleaning the glucometer with the Micro-Kill Bleach Germicidal Bleach Wipes, with no date, was provided by the Infection Preventionist (IP), on 3/14/22 at 11:52 a.m. A review of this document, indicated, " ...Special Instructions for Cleaning and Decontamination against HIV-1 (a virus that attacks the body's immune system), HBV (a serious liver infection), and HCV (a serious liver infection) on Surfaces/Objects soiled with Blood/Body Fluids. Personal Protection: When handling items soiled with blood or body fluids, use disposable gloves ... Cleaning Procedure: Blood/body fluids must be thoroughly cleaned from surface/objects before application of Micro-Kill Bleach Germicidal Bleach Wipes. Contact Time: Allow surface to remain wet for 30 seconds to kill all the bacteria and viruses on the label except number one contact time is required to kill Candida albicans (causes a yeast infection) and Trichophyton mentagrophytes (causes a fungus infection) and a 3 minute contact time is required to kill Clostridium difficile (causes bacterial inflammation in the colon) spores. Reapply as necessary to ensure that the surface remains wet for the entire contact time ...."			

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	03/15/2022

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

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	A current policy, titled, "Cleaning and Disinfection of Resident-Care Items and Equipment," dated October 2018, was provided by the DON, on 3/11/22 at 3:40 p.m. A review of the policy indicated, " ...Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers of Disease Control and Prevention) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard ...Reusable resident care equipment will be decontaminated and/or sterilized between residents according manufacturers' instructions ...." 3.1-25(b)			