STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Bedford	2111 Norton LN Bedford, IN 47421

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 35318 Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 3 of 3 residents reviewed for hospitalization . (Resident 67, Resident 94, Resident 15) Findings include: 1. Resident 67's clinical record was reviewed on 6/11/24 at 2:13 p.m. The diagnoses included, but were not limited to, lymphedema and fracture of the femur. Resident 67's progress notes indicated the resident was sent to the hospital on 2/19/24. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 34848 2. On 6/13/24 at 11:46 a.m., Resident 94's clinical record was reviewed. The diagnoses included, but were not limited to, heart failure and atrial fibrillation (a rapid and irregular heartbeat of the heart's upper chambers). A 3/16/24 progress note indicated the resident was sent to the hospital at 7:07 a.m., due to a critical digoxin lab (a test measures the amount of the heart medicine digoxin in the blood) result. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 36912 3. On 6/11/23 at 11:15 a.m., Resident 15's clinical record was reviewed. The diagnoses included, but were not limited to, epileptic spasms and unspecified intellectual disabilities. The resident was transferred to the hospital on 5/1/24. There was no documentation to indicate the resident and/or the resident's representative were notified of this transfer in writing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 1150 a.m., the Administrator provided the facility's policy,Holding Bed Space undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicated sending the resident and resident representative a copy of the Transfer and Discharge form in writing . During an interview on 6/13/24 at 10:50 a.m., the facility Administrator indicated the transfer/discharge form was not provided to the resident or resident's representative in writing for the hospital transfer. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 35318 Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 3 of 3 residents reviewed for hospitalization . (Resident 67, Resident 94, Resident 15) Findings include: 1. Resident 67's clinical record was reviewed on 6/11/24 at 2:13 p.m. The diagnoses included, but were not limited to, lymphedema and fracture of the femur. Resident 67's progress notes indicated the resident was sent to the hospital on 2/19/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. 34848 2. On 6/13/24 at 11:46 a.m., Resident 94's clinical record was reviewed. The diagnoses included, but were not limited to, heart failure and atrial fibrillation (a rapid and irregular heartbeat of the heart's upper chambers). A 3/16/24 progress note, indicated the resident was sent to the hospital at 7:07 a.m., due to a critical digoxin lab (a test measures the amount of the heart medicine digoxin in the blood) result. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. 36912 3. On 6/11/23 at 11:15 a.m., Resident 15's clinical record was reviewed. The diagnoses included, but were not limited to, epileptic spasms and unspecified intellectual disabilities. The resident was transferred to the hospital on 5/1/24. There was no documentation to indicate the resident and/or the resident's representative were notified of the facility bed hold policy in writing. During an interview on 6/13/24 at 10:15 a.m., the Administrator indicated the facility did not provide the resident nor the resident representative the notification of Bed-Hold forms in writing. The facility sent the forms with the resident when they transfer to another facility. On 6/12/24 at 1150 a.m., the Administrator provided the facility's policy,Holding Bed Space undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, 1. Upon admission and when a resident is transferred for hospitalization or for therapeutic leave . the business office will provide information concerning our bed-hold policy to the resident and the resident representative . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-12(a)(25) 3.1-12(a)(26)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 36912 Based on record review and interview, the facility failed to ensure a resident's Minimum Data Set assessment was electronically transmitted to the Center for Medicare and Medicaid Services system within 14 days of the final completion date for 1 of 1 residents reviewed for Resident . (Resident 12) Finding includes: On 6/13/24 at 10:00 a.m., Resident 12's clinical record was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure and anemia. The Discharge Minimum Data Set (MDS) assessment, dated 12/31/23, indicated the assessment was completed but not transmitted to the Center for Medicare and Medicaid Services system within 14 days of the completion date. During an interview on 6/13/24 at 3:25 p.m., the MDS Coordinator indicated the Discharge MDS assessment was not transmitted to the Center for Medicare and Medicaid Services system within 14 days of the completion date.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 34848 Based on interview and record review, the facility failed to ensure residents received an accurate Minimum Data Set (MDS) assessment, reflective of the resident's status at the time of the assessment for 2 of 22 residents reviewed for accuracy of assessments. (Resident 67, Resident 92) Findings include: 1. On 6/11/24 at 2:51 p.m., Resident 67's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 4/24/24, indicated the resident did not have an anxiety diagnosis. A review of the resident's current June, 2024, orders indicated on 4/10/24, the resident was prescribed lorazepam (an anti-anxiety medication) 0.5 milligrams, 3 times a day, for anxiety. During an interview on 6/13/24 at 11:55 a.m., the MDS Coordinator indicated the resident's MDS assessment was coded incorrectly and it should have reflected a diagnosis of anxiety. 2. On 6/13/24 at 3:15 p.m., Resident 92's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure and hypertension. The Discharge MDS assessment, dated 5/18/24, indicated the resident was discharged to a critical access hospital. A nursing note, dated 5/18/24 at 2:52 p.m., indicated the resident was discharged and transported to a different skilled nursing facility. During an interview on 6/13/24 at 3:53 p.m., the MDS coordinator indicated the resident's MDS assessment was coded incorrectly. 3.1-31(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35318 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for a resident with behaviors for 1 of 1 residents observed for behaviors. (Resident 60) Findings include: On 6/9/24 at 12:16 p.m., Resident 60 was observed to be sitting in the dayroom in a recliner. The resident was attempting to stand up and was yelling out, I'm gonna die. On 6/10/24 at 10:26 a.m., Resident 60 was observed to be sitting in the dayroom in a recliner. The resident was attempting to stand up and was yelling out, I'm gonna die. On 6/10/24 at 2:10 p.m., Resident 60 was observed to be sitting in the dayroom in a recliner. The resident was attempting to stand up and was yelling out, I'm gonna die. On 6/11/24 at 12:23 p.m., Resident 60 was observed to be sitting in the dayroom in a recliner. The resident was attempting to stand up and was yelling out, help me, I'm gonna die. On 6/12/24 at 11:23 a.m., Resident 60 was observed to be sitting in the dayroom in a recliner. The resident was yelling out, I'm gonna die. On 6/13/24 at 9:40 a.m., Resident 60 was observed to be sitting in the dayroom in the recliner yelling out, help me, I will die. On 6/13/24 at 9:40 a.m., Resident 60 was observed to be sitting at the dining room table in a wheelchair. The resident was observed to be yelling, I will die while the Activity Director was observed to be helping the resident eat some string cheese. Resident 60's clinical record was reviewed on 6/13/24 at 12:00 p.m. The diagnosis included, but was not limited to, anxiety disorder. Physician orders, dated 6/13/24, for Resident 60 indicated . ativan [anti-anxiety medication] oral tablet 0.5 mg [milligrams] give 1 tablet by mouth three times a day for anxiety . The Admission Minimum Data Set (MDS) assessment, dated 4/18/24, assessed Resident 60 as having behavioral symptoms directed toward others to be occurring daily and behavior symptoms not directed toward others as occurring 1-3 days during the 7 day look back period. A review of the care plans on 6/13/24 at 1:35 p.m., for Resident 60 indicated the resident did not have a care plan for exhibiting behaviors. During an interview on 6/13/24 at 12:00 p.m., RN 1 indicated Resident 60 constantly exhibited behaviors and they made attempts to redirect and reassure her when she was upset and yelling out. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 3:04 p.m., the Social Services Assistant indicated Resident 60 did not have a care plan for behaviors but probably should have one in place. 3.1-35(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38312 Based on observation, interview, and record review, the facility failed to provide treatment or services to prevent further decrease in range of motion for 3 of 5 residents reviewed for mobility. (Resident 29, Resident 63, Resident 79). Findings include: 1. During an interview on 6/10/24 at 11:07 a.m., Resident 29 indicated she had a stroke and her left side was affected. She had therapy for her left arm and hand contracture (permanent tightening of the muscle, tendon, skin, and nearby tissues that caused the joints to shorten and become stiff). When she was finished with therapy, they did not have a nursing restorative program to assist with her range of motion exercises. At that time, Resident 29 was observed to have a left hand contracture. On 6/12/24 at 2:57 p.m., Resident 29 was observed to be in her wheelchair. Her left hand and wrist were contracted and was resting on her lap. On 6/12/24 at 10:37 a.m., Resident 29's clinical record was reviewed. The diagnoses included, but were not limited to, cerebrovascular disease (stroke) affecting left side, hemiparesis (weakness on entire side of the body), muscle spasm, wrist contracture, and muscle weakness. The Discharge Notification from Therapy, dated 2/6/24, indicated the discharge recommendations were to continue with upper extremity home exercise program. The Occupational Therapy Discharge Summary, dated 2/16/24 at 12:06 p.m., indicated discharge recommendations of restorative range of motion program to her upper body. The Functional Abilities and Goals Assessment, dated 5/20/24 at 10:06 a.m., indicated Resident 29 had functional limitation of range of motion on one side of her upper and lower extremities. The Quarterly Minimum Data Set (MDS) assessment, dated 5/20/24, indicated Resident 29 was cognitively intact, had limited range of motion on one side of her upper and lower extremities, and was not on a active or passive range of motion restorative program. The care plan, dated 6/11/24 and current through target date of 9/11/24, indicated Resident 29 needed assistance with activities of daily living related to cerebrovascular disease with left sided hemiparesis. The care plan lacked documentation of active or passive range of motion or any services to prevent further decrease in range of motion. During an interview on 6/12/24 at 10:02 a.m., Certified Occupational Therapist Assistant (COTA) 1 indicated Resident 29 had a stroke and had functional limitation of her left upper extremity. When she was discharged from the occupational therapy, she would of benefited from a range of motion restorative program. The facility lacked a range of motion restorative program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 3:03 p.m., CNA 1 indicated Resident 29 had left-sided weakness and left hand contracture. Resident 29 did not have any active or passive range of motion restorative program. During an interview on 6/13/24 at 12:05 p.m., the Director of Health Services (DHS) indicated Resident 29 did not have a nursing restorative program or any services to prevent further decrease in range of motion of her left upper and lower extremity. 2. During an interview on 6/10/24 at 10:15 a.m., Resident 63's wife indicated he had a fall and had a traumatic brain injury. He was quadriplegic and had limited movement to his arms and legs. When Resident 63's therapy was finished, they did not recommend a range of motion restorative program because the facility did not have a restorative program. On 6/12/24 at 10:01 a.m., Resident 63 was observed to be sitting in his wheelchair in the day room with his wife. She was observed to raising his right arm and saying [Resident name] let's do your exercises. On 6/13/24 at 10:02 a.m., Resident 63 was observed to be sitting in the day room with his arms crossed on his chest. On 6/12/24 at 12:49 p.m., Resident 63's clinical record was reviewed. The diagnoses included, but were not limited to, traumatic brain injury and quadriplegia. The care plan, dated 6/29/23 and current through target date of 8/30/24, indicated Resident 63 needed assistance with activities of daily living. The care plan lacked documentation of active or passive range of motion or any services to prevent further decrease in range of motion. The Occupational Therapy Discharge Summary, dated 3/7/24 at 12:04 p.m., indicated recommendations of assistive device for safe functional mobility. The Functional Abilities and Goals Assessment, dated 4/20/24 at 1:38 p.m., indicated Resident 63 had functional limitation of range of motion on both sides of his upper and lower extremities. The Quarterly MDS assessment, dated 4/20/24, indicated Resident 63 had severe impaired decision making ability, had limited range of motion on both sides of his upper and lower extremities, and was not on a active or passive range of motion restorative program. During an interview on 6/12/24 at 3:03 p.m., CNA 1 indicated Resident 63 had limited range of motion to both upper and lower extremities. Resident 63 was not on a range of motion restorative program. During an interview on 6/13/24 at 10:50 a.m., COTA 1 indicated when Resident 63 was discharged from occupational therapy on 3/7/24, range of motion restorative program was not recommended because the facility did not have a restorative program. Resident 63 would benefit from a passive range of motion restorative program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 12:05 p.m., the DHS indicated Resident 63 did not have a nursing restorative program or any services to prevent further decrease in range of motion of both of his upper and lower extremities. 3. During an interview on 6/10/24 at 2:24 p.m., Resident 79 indicated she had broken her leg. She had therapy but was no longer getting any range of motion to her lower extremities. On 6/12/24 at 2:42 p.m., Resident 79's clinical record was reviewed. The diagnoses included, but were not limited to, tibia (shin bone) fracture, fall, muscle weakness, and difficulty in walking. The care plan, dated 8/29/23 and current through target date of 6/30/24, indicated Resident 79 needed assistance with activities of daily living. The care plan lacked documentation of active or passive range of motion or any services to prevent further decrease in range of motion. The Occupational Therapy Discharge Summary, dated 1/15/24 at 1:21 p.m., indicated recommendations of home exercise program. The Functional Abilities and Goals Assessment, dated 5/16/24 at 10:11 a.m., indicated Resident 79 had functional limitation of range of motion on one side of her lower extremities. The Quarterly MDS assessment, dated 5/16/24, indicated Resident 79 had moderately impaired cognition, had limited range of motion on one side of her lower extremities, and was not on an active or passive range of motion restorative program. During an interview on 6/12/24 at 2:59 p.m., CNA 1 indicated Resident 79 had a broken leg and was no longer on therapy caseload. Resident 79 was not on a restorative program because they did not have a restorative program. During an interview on 6/13/24 10:50 a.m., COTA 1 indicated the Occupational Therapy Discharge Summary, dated 1/15/24, indicated to discharge Resident 79 to a home exercise program because the facility did not have an active or passive restorative program. During an interview on 6/13/24 at 12:05 p.m., the DHS indicated Resident 79 did not have a nursing restorative program or any services to prevent further decrease in range of motion of her lower extremity. On 6/13/24 at 3:04 p.m., the DHS provided the facility policy, Prevention of Decline in Range of Motion, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, . b. The facility will provide treatment and care in accordance with professional standards of practice. this include, but is not limited to: 1. Appropriate services (specialized rehabilitation, restorative, and maintenance) .iii. Assistance as needed (active assisted, passive, supervision) . 3.1-42(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35318 Based on observation, interview and record review, the facility failed to ensure an open vial of insulin contained an open date for 1 of 1 resident reviewed for insulin during medication administration. (Resident 60) Findings include: During medication administration on 6/13/24 at 11:51 a.m., RN 1 was observed to remove an open vial of Humalog (insulin) from the medication cart and administer 2 units of insulin to Resident 60. The vial of Humalog was not observed to have an open date. Resident 60's clinical record was reviewed on 6/13/24 at 12:00 p.m. The diagnosis included, but was not limited to, type 2 Diabetes Mellitus. Physician orders, dated 6/13/24, for Resident 60 indicated . Humalog Injection Solution 100 unit/ml [milliliters] inject per sliding scale . During an interview on 6/13/24 at 11:53 a.m., RN 1 indicated the insulin was good for 90 days after it was opened and should have had an open date listed on the bottle. On 6/13/24 at 2:50 p.m., the Administrator provided the facility's policy,Labeling of Medications and Biologicals undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, . 8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed [needle punctured] . 3.1-25(j)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35318 Based on interview and record review, the facility failed to ensure laboratory services were provided for a resident with an order to obtain a blood draw every six months for 1 of 5 residents reviewed for unnecessary medications. (Resident 67) Findings include: Resident 67's clinical record was reviewed on 6/11/24 at 2:13 p.m. The diagnoses included, but were not limited to, lymphedema and fracture of the femur. Physician orders, dated 5/1/24 through 5/31/24, for Resident 67 indicated . cbc [complete blood count] with diff [differential] and bmp [basic metabolic panel] every 6 months due to HTN [hypertension] and CHF [congestive heart failure] . A review of the lab report dated 5/16/24 at 7:30 a.m., for Resident 67 indicated a CBC and BMP was attempted however the lab technician was unable to obtain an adequate sample for testing. A second phlebotomist would be sent. The clinical record lacked documentation of labs being completed on 5/16/24 nor a second attempt being made by another phlebotomist. During an interview on 6/13/24 at 12:13 p.m., the Nurse Practitioner indicated the labs from 5/16/24 were part of the admission follow up labs and the company providing the lab service did not come back to draw the labs. On 6/13/24 at 2:50 p.m., the Administrator provided the facility's policy,Laboratory Services and Reporting undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, . 2. The facility is responsible for the timeliness of the services . 3.1-49(a)