STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Lafayette	300 Windy Hill Dr Lafayette, IN 47905

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure food was prepared and served to conserve flavor and at a safe and appetizing temperature. This deficient practice had the potential to affect 91 of 92 residents whom received meal trays. Findings include:1. During an observation and interview, on 8/25/25 at 12:01 p.m., a meal tray was removed off a cart and placed on the counter at the nurses' station by Dietary Staff 3. Dietary Staff 3 removed the lid off the plate and proceeded to check the temperature of the food using a thermometer probe. The Salisbury steak registered at 92 degrees Fahrenheit, the whole kernel corn registered at 123.2 degrees Fahrenheit, and the sliced red potatoes registered at 85.2 degrees Fahrenheit. Dietary Staff 3 indicated the temperature of the food was not within range for serving, placed the tray back on the cart, and took it back to the kitchen to warm the food up. On 8/25/25 at 12:18 p.m., a sample tray was tasted. The whole kernel corn was bland, chewy, and cold. The peach cobbler was cold, dry, and lacked flavor. 2. During an observation and interview, on 8/22/25 at 12:38 p.m., Resident 25 was eating lunch in her room. She indicated her lunch was served cold. The food was always cold and had no flavor. During an observation and interview, on 8/25/25 at 12:10 p.m., Resident 25 was sitting on the side of the bed with her lunch in individual white foam containers. The resident was in contact isolation. She indicated she had just received her lunch tray. The potatoes and meat were ice-cold, and she wanted warm food. The resident indicated she had asked for a hamburger or her food warmed up. During an interview, on 8/25/25 at 12:12 p.m., Qualified Medication Aide (QMA) 16 indicated the resident's food would have to be warmed up. When asked about the resident being in contact isolation, QMA 16 indicated the kitchen would need to provide another tray. 3. During the resident council interview, on 8/28/25 at 1:36 p.m., three (3) residents indicated the food was served cold. One (1) resident indicated the food was cold whether you ate in the main dining room or in a dining room on the hall. One (1) resident indicated the eggs were like liquid. One (1) resident indicated the food sucks. During an interview, on 8/28/25 at 2:46 p.m., CNA 9 indicated everyday multiple residents would complain about cold food being served, the quality of the food, the food was not what they had ordered, or the food was not on the scheduled menu for the day. A current facility policy, titled Meal Distribution, dated as revised 2/2023 and received by the Clinical Support Nurse on 8/25/25 at 3:50 p.m., indicated .Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protect against contamination, and are delivered in a timely and accurate manner .All meals will be assembled in accordance with the (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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	individualized diet order, plan of care, and preferences .All food items will be transported promptly for appropriate temperature maintenance .The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to resident/patients .Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-serving dining 3.1-21(a)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a clean and comfortable environment was provided in 14 of 27 rooms and common areas reviewed for environment. (room [ROOM NUMBER], 210, 213, 124, 131, 137, 102, 103, and 114)Findings include:During an observation, on 8/22/25 beginning at 12:24 p.m., the following were observed:1. room [ROOM NUMBER] had black scuff marks on the lower portion of the wall below the dry erase board.2. On the cedarwood unit, the shower room door had chipped paint which exposed the wood to the middle and lower portion of the door.3. room [ROOM NUMBER] did not have trim on the wall around the thermostat controlling units. The exposed wall did not have paint and had a black fuzzy growth.4. room [ROOM NUMBER] did not have trim on the wall around the thermostat controlling units. The exposed wall did not have paint and had black and gray discolorations.5. room [ROOM NUMBER] did not have trim on the wall around the thermostat controlling units. The exposed wall was unpainted and had discolored drywall.6. room [ROOM NUMBER] did not have trim on the wall around the thermostat controlling units. The exposed wall was unpainted and had discolored drywall.7. room [ROOM NUMBER] did not have trim on the wall around the thermostat controlling units. The exposed wall was unpainted and had discolored drywall.8. room [ROOM NUMBER] had peeling paint on the wall and trim across from the foot of the bed.9. room [ROOM NUMBER] had peeling paint to the lower portion of the entrance side of the door.10. room [ROOM NUMBER] had peeling paint on the trim of the door.11. The ceiling tile, outside of room [ROOM NUMBER], had a stained dark brown circle.12. Across from the birchwood nurses' station, the corner edge trim was splintered and broken in half.13. On the birchwood unit, the lower half of the door to the shower room had black scuff marks and peeling paint.14. On the birchwood unit, the blind in the medication room was broken and hanging at a slant.15. On the entrance doors to the therapy department, the lower half was dirty with brown spots and black scuff marks, paint peeling, gold toned foot plates which had the plastic covering peeling.16. The interior front double doors had black scuff marks, chipped paint, and gouged wood on the lower half.17. The exterior front double doors had gouged wood, peeled paint, and rotted wood to the outer edges of the lower half of the doors.18. The exterior and interior entrance double doors had no door seals.19. The birchwood dining room's overhead lights were dim.20. The cedarwood dining area overhead light bulb was not working.21. The main dining room, birchwood dining room, and cedarwood dining room had all the tables without tablecloths, placemat settings or any table decor. During an observation, on 8/25/25 at 12:17 p.m., the wall thermostat setting indicated the temperature was 68 degrees Fahrenheit on the cedarwood unit.During an interview, on 8/25/25 at 10:18 a.m., Resident 12 indicated it was cold in the facility.During an interview, on 8/25/25 at 11:17 a.m., Employee 4 indicated it was cold in the facility.During an interview, on 8/25/25 at 11:50 a.m., LPN 5 indicated it was cold in the facility.During an interview, on 8/25/25 at 12:09 p.m., Resident 77 indicated it was cold in the facility.During an interview, on 8/25/25 at 12:11 p.m., RN 6 indicated it was cold in the facility. During a tour of the cedarwood unit with the Maintenance Supervisor and the Executive Director (ED), the temperature of the halls was 67 degrees Fahrenheit. The ED indicated the temperature level in the facility should be between 71-81 degrees Fahrenheit.During a tour of the facility with the Maintenance Supervisor and the Executive Director, they indicated the wall units in the rooms needed the trim placed around them, the other areas needed the paint touched up, trim replaced, lighting adjusted, ceiling tiles replaced, doors repaired and temperature settings adjusted in order to be maintained at the state regulation levels. A maintenance director job description, last updated 3/2021, indicated responsibilities included the supervision of the maintenance department and for the efficient function of physical and environmental systems.A current facility policy, dated 1/2/24, indicated the heating, ventilation and air conditioning system should be inspected semi-annually.The facility was unable to (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide any further policies related to environment. This citation relates to Intake 2583804.3.1-19(f)(5)3.1-19(h)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the resident's representative received notification in writing of the facility's bed hold policy and the reason for the resident's transfer and discharge to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 3)Findings include:The clinical record for Resident 3 was reviewed on 8/27/25 at 6:49 p.m. The diagnoses included, but were not limited to, diabetes mellitus, dementia, chronic kidney disease stage 3, hypertension, osteoarthritis, depression, anxiety, and hyperlipidemia. A nursing progress note, dated 3/14/25 at 6:59 p.m., indicated Resident 3 was hospitalized . The clinical record did not include documentation to indicate the bed hold policy or the reason for transfer was provided to the resident's representative in writing. During an interview, on 8/28/25 at 4:18 p.m., the Director of Nursing (DON) indicated there was no documentation the bed hold policy or the reason for transfer was provided to the resident representative in writing. A current facility policy, titled Holding Bed Space, dated as revised on 6/1/18 and received from the DON on 8/27/25 at 2:15 p.m., indicated .our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy .a representative of the business office will provide information concerning our bed-hold policy to the resident and the resident representative .when emergency transfers are necessary, the facility will provide the resident, resident representative .with information concerning our bed-hold policy with the transfer .the bed-hold information will include any charges that the resident may incur 3.1-12(a)(6)(A)(i)3.1-12(a)(6)(A)(ii)3.1-12(a)(6)(A)(iii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure showers were given according to the scheduled shower days and were accurately documented for 1 of 5 residents reviewed for activities of daily living. (Resident C)Findings include:During an interview, on 8/21/25 at 10:40 a.m., Resident C indicated her shower days were scheduled in the morning every Tuesday and Thursday but due to the facility being short staffed, she had not been able to get into the shower to have her hair washed. Resident C indicated she needed a Hoyer lift for transferring which required two staff members. She indicated sometimes she did request a bed bath instead of a shower. Resident C indicated she had filed a grievance before related to not receiving a shower.The clinical record for Resident C was reviewed on 8/26/25 at 1:34 p.m. The diagnoses included, but were not limited to, major depressive disorder, metabolic encephalopathy, and type 2 diabetes mellitus.A care plan, dated 9/24/23 and last revised on 7/11/25, indicated Resident C preferred a bed bath. She would refuse showers and then tell her family she had not been given showers. The interventions included, but were not limited to, note refusals and offer a bed bath if the resident did not feel like taking a shower.A care plan, dated 5/7/25, indicated Resident C required assistance with activities of daily living (ADL) care with an intervention to assist with ADLs as needed.1. During an observation and interview, on 8/26/25 at 11:07 a.m., Resident C indicated the CNA had not come to ask if she would like to have her shower yet. Resident C indicated she wanted to get a shower today so her hair could be washed. Resident C's hair was observed to be slightly greasy. Resident C indicated she was going to turn on her call light and ask about her shower.During an observation and interview, on 8/26/25 at 2:35 p.m., Resident C indicated she still had not received a shower, and she had asked CNA 13 if she would get her shower today. Resident C stated CNA 13 told her She didn't know because state was in the building, and she has a lot of things to do. Resident C's hair was still observed to be slightly greasy.During an interview, on 8/26/25 at 2:39 p.m., the Assistant Director of Nursing indicated it was currently change of shift and CNA 13 had already left the building for the day. She was not sure if Resident C had a shower today.A review of the CNA tasks in the electronic health record indicated CNA 13 documented at 1:59 p.m., Resident C had been given a shower with the physical support of two people.During an interview, on 8/26/25 at 2:45 p.m., the Assistant Director of Nursing indicated a shower sheet could not be located for Resident C's shower on 8/26/25.During an interview, on 8/27/25 at 12:15 p.m., CNA 13 indicated she did not give Resident C a shower on 8/26/25. She thought she documented the shower as did not occur. CNA 13 indicated she did not have enough time after lunch to get all her stuff done, which was why Resident C did not receive a shower. The shower sheets had been moved, and she did not have time to look for them, so she did not complete a shower sheet for any showers she had given on 8/26/25.2. A review of the resident council meeting minutes indicated in the month of May 2025; residents were not receiving showers on their scheduled shower days.A facility document, titled C.N.A. Shower & Skin Care Alert Sheet, dated 7/3/25, was signed by CNA 16 and indicated Resident C was given a shower on 7/3/25.A facility grievance, dated 7/7/25, indicated Resident C reported she did not receive her scheduled shower on 7/3/25. The findings indicated Resident C did not receive a shower on 7/3/25. She was offered a shower on 7/4/25 but declined and would continue her previous shower schedule. The corrective action taken for the grievance was staff education.During an interview, on 8/26/25 at 3:08 p.m., the Director of Nursing indicated staff should complete a shower sheet with every shower or bed bath provided. If a resident refused a shower or bed bath, three separate attempts would be made to provide the shower or bed bath. If the resident refused all three attempts, the resident, CNA and the nurse would sign the shower sheet as refused. The Director of Nursing indicated she had been made aware staff were documenting showers which had not been done. She did not know why CNA 13 documented Resident C's shower had been given if the CNA did not actually give Resident C her shower and this was unacceptable.A CNA job description, dated 3/2025 and received from the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing on 8/27/25 at 11:23 a.m., indicated .Essential responsibilities.to perform or assist the resident with completing Activities of Daily Living (ADL).Maintain effective communication with residents, families and community staff.documentation of room visits.perform other tasks as assigned.This position requires for the care team member to be able to perform and complete each essential duty satisfactorily.A current facility policy, titled Activities of Daily Living (ADLs), dated 1/2/24 and received from the Director of Nursing on 8/27/25 at 11:23 a.m., indicated .Care and services will be provided for the following activities of daily living.Bathing, dressing, grooming and oral care.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.A current facility policy, titled Resident Rights, dated 1/2/24 and received from the Director of Nursing on 8/27/25 at 11:23 a.m., indicated .The resident has the right to be informed of, and participate in, his or her treatment, including.the right to receive the services and/or items included in the plan of care.The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living.This citation relates to Intakes 1818839, 1818840 and 2583804.3.1-38(a)(2)(A)3.1-38(a)(3)(B)3.1-38(b)(2)3.1-38(b)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure medications were held and laboratory tests were obtained according to the physician's orders for 2 of 6 residents reviewed for quality of care. (Resident 28 and 77)Findings include:1. The clinical record for Resident 28 was reviewed on 8/25/25 at 9:53 a.m. The diagnoses included, but were not limited to, chronic diastolic congestive heart failure, paroxysmal atrial fibrillation, and type 2 diabetes mellitus with diabetic chronic kidney disease. A care plan, dated 1/24/25, indicated Resident 28 was at risk for impaired cardiac output and to administer medications as ordered, obtain vital signs as ordered, and to notify the physician of abnormalities. A care plan, dated 1/24/25, indicated Resident 28 was receiving Digoxin (a medication used to treat congestive heart failure) and to check the pulse prior to administering the medication. a. A physician's order, dated 1/8/25, indicated to administer Digoxin 125 milligrams (mg) by mouth once a day every Wednesday and Sunday, with instructions to hold the medication for a heartrate below 60 and to notify the physician. The Medication Administration Record (MAR) for June indicated Digoxin was given with a heart rate less than 60, on 6/15/25, with no physician notification documented. b. A physician's order, dated 5/2/25, indicated to administer midodrine (a medication used to treat orthostatic hypotension) 5 mg by mouth twice a day every 8 hours, with instructions to hold the medication for a systolic blood pressure greater than 140 and diastolic blood pressure greater than 100. The MAR for June indicated midodrine was administrated outside of the physician's ordered parameters on 6/3/25 in the morning, on 6/6/25 in the afternoon, on 6/15/25 in the morning, and on 6/22/25 in the morning. The medication was documented as held and not administered on 6/8/25 and 6/22/25 when the physician's ordered parameters were within normal limits. The MAR for July indicated midodrine was administrated outside of the physician's ordered parameters on 7/4/25 in the morning, on 7/8/25 in the morning, on 7/13/25 in the morning, on 7/14/25 in the morning, on 7/19/25 in the morning, and on 7/22/25 in the morning. The medication was documented as held and not administered on 7/14/25, 7/15/25, 7/20/25 and 7/25/25 when the physician ordered parameters were within normal limits. The MAR for August indicated midodrine was administrated outside of the physician's ordered parameters on 8/2/25 in the evening, on 8/10/25 in the evening, on 8/18/25 in the morning, and on 8/21/25 in the evening. The medication was documented as held and not administered on 8/24/25 when the physician's ordered parameters were within normal limits. c. A physician's order, dated 7/30/25, indicated to administer metoprolol (a medication used to treat blood pressure) 25 mg (a half tab) twice a day, with instructions to hold the medication for a systolic blood pressure less than 105 or a heart rate less than 60. The MAR for June indicated metoprolol was administrated outside of the physician's ordered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	parameters on 6/2/25 in the evening and 6/23/25 in the morning. The MAR for August indicated metoprolol was administrated outside of the physician's ordered parameters on 8/8/25 in the morning. The medication was documented as held and not administered on 8/1/25 and 8/13/25, when the physician's ordered parameters were within normal limits. During an interview, on 8/25/25 at 2:14 p.m., the Director of Nursing (DON) indicated a check mark documented on the MAR meant the medication was administered. The medications were being administered outside of the physician's ordered hold parameters. During an interview, on 8/27/25 at 10:05 a.m., Registered Nurse (RN) 15 indicated a check mark on the MAR indicated the medication was administered. If the medication was held or the order indicated to notify the physician, the nurse would document a 4 on the MAR and the notification to the physician would be documented in the progress notes. 2. The clinical record for Resident 8 was reviewed on 8/25/25 at 12:53 p.m. The diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, and anxiety disorder. A physician order, dated 8/31/22, indicated to administer Depakote Sprinkles 125 mg twice a day for bipolar disorder. A physician's order, dated 2/17/24, indicated Depakote levels were to be obtained every six months, starting on the 17th. A review of Resident 8's laboratory results indicated a Depakote level was obtained on 12/5/24 and would be due again, according to the physician's order, in June 2025. A Depakote level in June 2025 was not located in the electronic health record. A psychiatric nurse practitioner progress note, dated 7/26/25, indicated there were no new labs available for review in the facility's electronic health record. During an interview, on 8/27/25 at 9:40 a.m., the DON indicated she needed to review the electronic health record. A current facility policy, titled Medication Administration, dated 1/2/24 and received from the DON on 8/27/25 at 11:22 a.m., indicated .When applicable, hold medication for those vital signs outside the physician's prescribed parameters. A current facility policy, titled Physicians Orders, dated 1/2/24 and received from the DON on 8/27/25 at 11:21 a.m., indicated .facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders .Qualified nursing personnel will submit timely requests for physician orders services (laboratory, radiology, consultations) to the appropriate entity 3.1-37(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview and record review, the facility failed to ensure routine maintenance inspections which included following the manufacturers' recommendations and specifications for maintaining the bed rails were documented for 2 of 2 residents reviewed for bed rails. (Resident 8 and 10)Findings include:1. During an observation and interview, on 8/22/25 at 10:10 a.m., Resident 8's bed was observed to have bilateral bed rails. Resident 8 indicated the bedrail on the right side (the side of the bed she used to get in and out of the bed) was very loose. She could not recall the last time she had seen a staff member inspect her bedrails. She had not requested a work order for the loose bed rail but indicated the nurses and CNAs knew her bed rail was loose.The clinical record for Resident 8 was reviewed on 8/25/25 at 12:53 a.m. The diagnoses included, but were not limited to, fracture of the left lower leg, displaced fracture of the medial malleolus of the left tibia, and anxiety disorder.A physician's order, dated 9/19/22, indicated Resident 8 was to utilize bed rails as an enabler for turning and repositioning while in bed.Work orders submitted for maintenance by other staff members, from 5/26/25 to 8/26/25, did not include Resident 8's loose bed rail.During an observation and interview, on 8/26/25 at 12:12 p.m., the Maintenance Supervisor observed Resident 8's bed rail and indicated the right bed rail was loose when he grabbed onto the rail. The bed rails were well used and they become wiggly. He indicated he did not believe he had the manufactures instructions for the bed rail anymore.2. During an observation, on 8/22/25 at 9:20 a.m., Resident 10 was lying in bed. The bed had bilaterally padded side rails in the raised position.The clinical record for Resident 10 was reviewed on 8/26/25 at 8:57 a.m. The diagnoses included, but were not limited to, epilepsy, paranoid schizophrenia, and conversion disorder with seizures or convulsions.A physician's order, dated 7/31/24, indicated Resident 10 was to utilize padded bed rails as an enabler for safety.A care plan, dated as last revised on 3/2/25, indicated Resident 10 had a diagnosis of epilepsy with an intervention of padded side rails as ordered for seizure precautions.Documentation of routine maintenance inspections which followed the manufacturers' recommendations and specifications were not documented for in the clinical records for Resident 8 and 10.During an interview, on 8/26/25 at 12:05 p.m., the Maintenance Supervisor indicated inspecting bed rails was a monthly task performed for the entire building. He did not document which rooms or bed rails were inspected. If staff observed an issue with a bed rail, they would submit a work order to the maintenance department and the maintenance staff would follow up on the work order.A current facility policy, titled Bed Rails, dated 1/2/24 and received from the Director of Nursing (DON) on 8/12/25 at 11:24 a.m., indicated .If bed rails are used, the facility ensures correct installation, use and maintenance of the rails.The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes.Checking bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time.Conducting routine preventative maintenance of bed and bed rails to ensure they meet currently safety standards and are not in need of repair.Ongoing monitoring and supervision.Responsibilities of ongoing monitoring and supervision are specified as follows.The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails.3.1-45(a)(1)3.1-45(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Lafayette	300 Windy Hill Dr Lafayette, IN 47905

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure irregularities in the drug regimen were recognized, reported, and addressed for 2 of 5 residents reviewed for unnecessary medications. (Resident 8 and 28)Findings include:1. The clinical record for Resident 8 was reviewed on 8/25/25 at 12:53 p.m. The diagnoses included, but were not limited to, bipolar disorder, personal history of pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot), and anxiety disorder.a. A care plan, dated 9/11/22, indicated Resident 8 was at risk for increased bruising or bleeding due to anticoagulant therapy. An intervention indicated for the pharmacist to review the medication regime routinely.A physician's order, dated 12/21/23, indicated Resident 8 was to take apixaban (also known as Eliquis, an anticoagulant used to prevent blood clots) every twelve hours for post operative instructions.The medication regimen reviews (MMR), dated 1/1/25 to 8/3/25, were reviewed and there were no irregularities reported related to obtaining a supportive diagnosis or clarification for the medication ordered as a post operative instruction in 2023.b. A care plan, dated 9/11/22, indicated Resident 8 received psychotropic medications (or psychotropic like medications) and was at risk for adverse side effects of the mood stabilizer (Depakote).A care plan, dated 8/23/23, indicated Resident 8 was at risk for alterations in mood and was taking a mood stabilizer. An intervention was for the pharmacist to review the medication regime and to notify the physician of recommendations.A physician's order, dated 8/31/22, indicated to administer Depakote Sprinkles (used to help treat manic episodes associated with bipolar disorder) twice a day related to bipolar disorder.A physician's order, dated 2/17/24, indicated the facility was to obtain a Depakote level laboratory blood draw every six months starting on the 17th.Resident 8's laboratory results indicated the Depakote level was last obtained on 12/5/24.A Depakote level for the month of June 2025 was not located in the electronic health record for when the blood sample would have been collected.A psychiatric nurse practitioner's note, dated 7/26/25, indicated there were no new labs available for review in the facility's electronic health record.The medication regimen reviews (MMR), dated 6/1/25 to 8/3/25, were reviewed and there were no irregularities reported related to obtaining the missing laboratory orders. During an interview, on 8/27/25 at 9:40 a.m., the Director of Nursing (DON) indicated the order for Apixaban was placed a couple of years ago after a surgical procedure. The diagnosis for the medication was no longer appropriate and should have been reported as an irregularity through the medication regimen review. She needed to review the electronic health record related to the laboratory order.2. The clinical record for Resident 28 was reviewed on 8/25/25 at 9:53 a.m. The diagnoses included, but were not limited to, chronic diastolic heart failure, paroxysmal atrial fibrillation, and type 2 diabetes mellitus with diabetic chronic kidney disease.A physician's order, dated 5/2/25, for Midodrine (a medication used to treat orthostatic hypotension or low blood pressure) did not include a supporting diagnosis which indicated the clinical need for the use of the medication.The medication regimen reviews (MMR), dated 1/1/25 to 8/3/25, were reviewed and there were no irregularities reported related to obtaining a supportive diagnosis or clarification for the medication ordered.During an interview, on 8/27/25 at 2:48 p.m., the DON indicated the medication was missing a diagnosis. She indicated she was not sure how the order got through the system without a supporting diagnosis.A current facility policy, titled Pharmacy Services, dated 1/2/24 and received from the DON on 8/27/25 at 11:23 a.m., indicated .It is the policy of this facility to ensure that pharmaceutical services.are consistent with state and federal requirements, and reflect current standards of practice.The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements.3.1-25(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure two step Tuberculous tests were completed following acceptable guidelines for 2 of 5 residents reviewed for infection control. (Resident 25 and 48) Findings include: 1. The clinical record for Resident 25 was reviewed on 8/28/25 at 10:30 a.m. The diagnoses included, but were not limited to, cutaneous abscess of the buttock, necrotizing fasciitis, diabetes mellitus, hypertension, bipolar disorder, anxiety disorder, depression, and chronic pain syndrome.The Electronic Health Record (EHR), for Resident 25, indicated:a. the first-step tuberculous test, dated 5/18/25 at 10:15 p.m., was marked as not applicable (NA). The test was documented as read on 5/18/25 at 10:04 p.m. b. the second-step tuberculous test was documented as administered on 5/31/25 at 3:56 a.m. and was read on 6/1/25 at 10:22 p.m., less than 48 hours. 2. The clinical record for Resident 48 was reviewed on 8/28/25 at 2:37 p.m. The diagnoses included, but were not limited to, diabetes mellitus, colostomy, depression, hypertension, and presence of a cardiac pacemaker. The Electronic Health Record (EHR), for Resident 48, indicated:a. the first-step tuberculous test was documented as administered on 2/19/25 at 2:03 p.m. The test was documented as read on 2/20/25 at 10:19 p.m., less than 48 hours.b. the second-step tuberculous test was documented as administered on 3/12/25 at 9:21 a.m. and was read on 3/13/25 at 10:46 p.m., less than 48 hours. During an interview, on 8/28/25 at 2:56 p.m., the Director of Nursing (DON) indicated the tuberculous tests for Residents 25 and 48 were not done correctly. The tests were read too soon and would need to be completed again. The tests needed to be read a minimum of 48 hours after they were administered. A current facility policy, titled Tuberculosis, Screening Residents, dated as revised 11/2016 and received from the DON on 8/28/25 at 3:22 p.m., indicated .This facility shall screen all residents for tuberculosis infection and disease (TB). In all cases, state regulation/law will supersede this policy. Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test (last dated January 31, 2025) and retrieved on 9/8/25 from The Centers for Disease Control and Prevention indicated .The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TB skin results.A patient who does not return within 72 hours will need to be rescheduled for another skin test. There is no risk associated with repeated TB skin test placements. There is no contraindication to repeating the TB skin test. 3.1-18(e)