

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/24/2024
NAME OF PROVIDER OR SUPPLIER  Majestic Care of McCordsville		STREET ADDRESS, CITY, STATE, ZIP CODE  7476 W Lane Rd McCordsville, IN 46055	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942</b></p> <p>Based on interview, observation, and record review, the facility failed to assist a female dependent resident with perineal care in a manner to promote infection control, provide a dependent resident hair shampooing per her preference, to providing bathing type to a dependent resident's preference, and ensure availability of assistive devices for 1 of 2 residents reviewed for activities of daily living (Resident D). The facility failed to implement the use of long sleeves as a preventative measure for a resident with skin impairments for 1 of 1 residents reviewed for non-pressure skin impairments (Resident 9).</p> <p>Findings include:</p> <p>1. The clinical record for Resident 9 was reviewed on 5/22/24 at 2:52 p.m. The diagnoses included, but were not limited to, anorexia, generalized anxiety disorder, and dementia.</p> <p>An admission minimum data set (MDS) assessment, dated 3/19/24, indicated severe cognitive impairment and the need for supervision/touching assistance with upper body dressing and partial/moderate assistance with personal hygiene.</p> <p>A skin care plan, dated 4/2/24, indicated Resident 9 had chronic bruising and was at risk for bruising to bilateral arms due to thin fragile skin.</p> <p>A skin impairment care plan, dated 5/20/24, indicated Resident 9 had a skin tear to left lateral arm (elbow) and upper left arm abrasion.</p> <p>There were no interventions on the care plans that consisted of preventative measures such as wearing long sleeves or geri sleeves (protective arm sleeves). There were no current physician orders for geri sleeves.</p> <p>A skin and wound note, dated 3/26/24, indicated a skin tear to the right elbow with a recommendation to consider geri-sleeves for protection. Resident 9 had a skin tear related to thin, fragile, atrophic skin. Recommended preventing further skin injury by avoiding friction/shear and long sleeves and pants when possible.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A skin and wound note, dated 4/2/24, indicated a skin tear to the right elbow, left hand, left wrist, and left elbow. A recommendation listed to consider geri-sleeves for protection. Resident 9 had a skin tear related to thin, fragile, atrophic skin. Recommended preventing further skin injury by avoiding friction/shear and long sleeves and pants when possible.</p> <p>A skin and wound note, dated 5/21/24, indicated Resident 9 had fallen and obtained a skin tear to the left posterior arm and left elbow. Treatment recommendations were to consider geri-sleeves. Recommended preventing further skin injury by avoiding friction/shear and long sleeves and pants when possible.</p> <p>An observation conducted on 5/21/24 at 11:05 a.m., of Resident 9 lying in bed with short sleeves on and no geri sleeves in place.</p> <p>An observation conducted on 5/21/24 at 11:57 a.m., of Resident 9 lying in bed with short sleeves on and no geri sleeves in place.</p> <p>An observation conducted on 5/22/24 at 4:45 p.m., of Resident 9 up in the wheelchair in his room with a short sleeve on and no geri sleeves in place.</p> <p>An interview conducted with the Director of Nursing (DON), on 5/23/24 at 3:07 p.m., indicated Resident 9 would remove gauze wraps and geri sleeves when it was trialed with him. They believed Resident 9 wearing long sleeves would be a different approach to attempt with him as an intervention.</p> <p>A policy titled Skin Management, dated January 2022, was provided by the DON on 5/23/24 at 9:25 a.m. The policy indicated the following, .PREVENTION .a) Care plan interventions will be implemented based on resident specific risk factors .7. Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place .a) A care plan will be developed specific to the resident's needs including prevention interventions</p> <p>45291</p> <p>2. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnosis included a history of stroke.</p> <p>An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact, did not have psychosis, did have verbal behaviors directed at others 1-3 days during the review period, and did not reject care. Activities of daily living indicated that Resident D was dependent on staff for showering/bathing and for transferring.</p> <p>An activities of daily living care plan, dated 4/17/2023, indicated that Resident D needed assistance of one staff to prove her with bathing on her shower days and assistance of one staff for hygiene needs.</p> <p>A fall care plan, dated 4/29/2023, indicated to keep Resident D's call light within reach.</p> <p>A respiratory care plan, dated 4/17/2023, indicated for Resident D to utilize oxygen as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician order, dated 12/5/2023, indicated for Resident D to have oxygen therapy at three liters per minute.</p> <p>A preference assessment, dated 3/22/2024, indicated that it was very important for Resident D to make decisions regarding her bathing.</p> <p>A task, dated 12/4/2023, indicated for Resident D to receive showers on Monday and Thursday evenings.</p> <p>An observation on 5/21/2024 at 12:09 p.m., indicated CNA 4 and CNA 5 provided Resident D with a bed bath, perineal care, catheter care, and transfer from her bed to her wheelchair. During this care, Resident D did not receive shampooing of the hair but was set up to brush her hair once in the wheelchair. At the beginning of the care, Resident D was observed to utilize oxygen via nasal cannula at three liters per minute. During the observation at 12:22 p.m., CNA 5 assisted Resident D to roll towards CNA 4. CNA 5 assisted Resident D with cleaning a small amount of bowel movement. Resident D was indicated that staff had not gotten her cleaned up well enough over the weekend and she felt like she was sore down there. CNA 5 wiped from the anus towards the vaginal opening, folded the washcloth to repeat this, then repeated this actions once more. CNA 5 discarded the used washcloth then changed her gloves then used a new washcloth to wipe off Resident D's bottom of the soapy residue. Later in that observation on 5/21/2024 at 12:50 p.m., Resident D had her oxygen removed due to it becoming tangled when her shirt when she was dressed in bed. Both CNAs began assisting Resident D to untangle the oxygen but neither placed it back upon Resident D. CNA 4 exited the Resident's room at 12:55 p.m. CNA 5 left the room at 12:57 p.m. to retrieve something from outside of the room. Resident D was left in bed without a staff member present with the foot of her bed pulled out from the wall, her call light was not given to her, and her oxygen was not placed. At 12:58 p.m., Resident D began to call out loudly that she could not breath without her oxygen and that she needed her oxygen. At 12:00 p.m. both CNAs returned to the room. Resident D was still calling out for her oxygen and ice pack. CNA 5 placed the oxygen back to Resident D via her nasal cannula and informed her that the staff were able to get her up to her recliner.</p> <p>An interview and observation with Resident D on 5/21/2024 at 4:01 p.m. indicated that she was blind after her stroke. She stated that she had not had her hair washed since March of this year and that her hair smelled to her. Her hair appeared somewhat unkempt, specifically at the nape of her neck where it appeared tangled with some slight build up. She stated her preference was to have a shower in the shower room, but she has been here a year, and no one has ever taken her into the shower room. She stated she doesn't feel like bed baths get her clean enough. She stated she would like to receive showers every day since that was her routine when she could care for herself, but she understands that isn't possible. She iterated instead she was comfortable with receiving showers and have her hair shampooed twice a week like everyone else with her bed baths in between, but she stated she is not receiving showers in the shower room or shampooing of her hair. She indicated she does not like to use shampoo caps because they leave residue in her hair.</p> <p>A shower sheet was provided for Resident D, dated 5/21/2024. There was a place to indicate yes or no if a shower was given, and what type of bathing was provided such as a bed bath, shower, or resident refused. Both locations were left blank.</p> <p>Review of the electronic care documentation indicated that Resident D last documented hair wash under this task was on 5/2/2024.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of previous shower sheets had types of bathing (shower, bed bath, completed bed bath) indicated intermittently, but not always. The last documented complete bed bath from the paper shower sheets was completed on 5/16/2024. A shower sheet from 5/19/2024 did not indicate what type of bathing or care was provided.</p> <p>An interview with Resident D with staff on 5/23/2023 at 12:09 p.m., indicated she preferred showers and had not had her hair shampooed since March of this year. Resident D stated again that her hair smelled and asked a staff member conducting the interview how often they washed their hair. In response to the staff member's answer, Resident D stated that she wanted her hair shampooed twice a week.</p> <p>An interview with the Executive Director on 5/23/2024 at 3:20 p.m. indicated that shower preferences would be indicated under the resident's tasks.</p> <p>An interview with Resident D on 5/24/2024 at 12:48 p.m. reiterated that she had not received a shower in the shower since her admission here and did not have her hair shampooed since March of this year.</p> <p>A document entitled, Resident Rights, was provided by the Director of Nursing on 5/23/2024 at 3:15 p.m. The resident's right included the right to be informed of, and participate in, the resident's treatment including the right to determine the type, frequency, and [NAME] of care. Another resident right was indicated as the right to make choices about aspects of the resident's life in the facility that are significantly important to the resident.</p> <p>A policy entitled, Perineal Care, was provided by the Director of Nursing on 5/21/2024 at 3:15 p.m. The policy indicated, .Cleanse buttocks and anus, front to back; vagina to anus in females .</p> <p>A policy entitled, Use of Assistive Devices, was provided by the Executive Director on 5/22/2024 at 4:55 p.m. The policy indicated that the facility would provide assistive devices for residents as needed.</p> <p>This Federal tag relates to Complaint IN00432944.</p> <p>3.1-3(v)(1)</p> <p>3.1-38(a)(2)(A)</p> <p>3.1-38(a)(3)(B)</p> <p>3.1-47(a)(6)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45291</p> <p>Based on interview, observation, and record review, the facility failed to implement the use of padded side rails for two residents with a care planned for seizure disorders (Resident 9 and Resident D) and failed to utilize a Hoyer lift pad to the manufacturer's guidelines for 1 of 2 residents reviewed for accidental hazards. (Resident D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 9 was reviewed on 5/22/2024 at 2:33 p.m. The medical diagnoses included dementia and psychosis disorder.</p> <p>An Admission Minimum Data Set (MDS) Assessment, dated 3/19/2024, indicated that Resident 9 was cognitively impaired and had a seizure disorder or epilepsy.</p> <p>A seizure care plan, dated 3/8/2024, indicated for Resident 9 to utilize padded side rails.</p> <p>An observation on 5/21/2024 at 11:05 a.m. indicated Resident 9 laying in bed with a white bed without padding.</p> <p>An observation on 5/22/2024 at 2:45 p.m. indicated Resident 9 laying in bed with a white bed rail without padding.</p> <p>An interview with LPN 3 on 5/22/2024 3:01 p.m., indicated that Resident 9's bed rails were not padded.</p> <p>2. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnosis included a history of stroke.</p> <p>An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact, did not have psychosis, did have verbal behaviors directed at others 1-3 days during the review period, and did not reject care. Activities of daily living indicated that Resident D was dependent on staff for showering/bathing and for transferring.</p> <p>A seizure care plan, dated 4/17/2023, indicated for Resident D to utilize padded side rails.</p> <p>An observation on 5/21/2024 at 12:13 p.m. indicated Resident D laying in bed without padded side rails.</p> <p>An observation on 5/22/2024 at 2:40 p.m. indicated Resident D laying in bed without padded side rails.</p> <p>An interview with CNA 6 on 5/22/2024 at 2:42 p.m. indicated Resident D did not have padded side rails.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A policy entitled, Use of Assistive Devices, was provided by the Executive Director on 5/22/2024 at 4:55 p.m. The policy indicated that the facility would provide assistive devices as needed for residents.</p> <p>A fall care plan, dated 4/29/2023, indicated Resident D had a transfer status that required the use of two staff members and a Hoyer (full body mechanical) lift.</p> <p>An interview and observation on 5/21/2024 at 1:12 p.m. indicated CNA 5 rolled Resident D towards the wall where CNA 4 was located. The Hoyer lift sling was placed partially under Resident D. CNA 4 then assisted Resident D in rolling back to the right side of her bed, open to the center of the room, to finish placing the Hoyer lift sling under Resident D. CNA 5 obtained the Hoyer lift from the center of the room and began to lower the arm of the lift for ease of placing the loops. CNA 4 indicated white to CNA 5 to direct that color of loop they would utilize to lift Resident D. CNA 4 and CNA 5 placed the loops upon the lift support hooks starting with Resident D's left shoulder then left leg, right leg, and finishing with the right shoulder. The leg straps were placed on the Hoyer lift support hook without crossing the leg straps. During the placement of the loops, they had to pause to lower the arm slightly more due to tension when placing the last loop associated with the right shoulder. At 1:17 p.m. on 5/21/2024, CNA 5 guided the lift and CNA 4 guided Resident D. CNA 4 helped turn Resident D once she was suspended in the sling and moved from the bed to straddle the boom of the Hoyer lift while CNA 5, at the control of the lift, helped guide Resident D's leg to move around the boom. The staff attempted to get Resident D into her recliner per her request, but the recliner was noted to not be plugged. CNA 4 went behind the recliner, sliding it out from the wall some, and then picked up a black cord but was unable to find where it plugged in. Resident D began to loudly state that her back hurt and that she was slipping. Resident D then agreed to get in her wheelchair. CNA 4 repositioned Resident D's wheelchair to be placed in the middle of the room, facing the room door, before Resident D was then maneuvered into her wheelchair.</p> <p>A policy entitled, Safe Resident Handling/Transfers, was provided by the Director of Nursing on 5/21/2024 at 3:15 p.m. The policy indicated, .Staff will perform mechanical lifts/ transfers according to the manufacturer's instructions for use of the device .</p> <p>An Operator's Manual for the Hoyer lift utilized was provided by the Executive Director on 5/22/2024 at 12:49 p.m. The manual indicated when attaching the sling to lift to attach right shoulder strap to the nearest sling support hook then repeat for the left shoulder strap. The manual emphasized not to crisscross the shoulder straps. The manual indicated to be sure leg straps are properly crisscross as shown in a diagram then attached to sling support hooks away from the resident.</p> <p>This Federal tag relates to Complaint IN00432944.</p> <p>3.1-45(a)(2)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>36942</p> <p>Based on interview and record review, the facility failed to have a Registered Nurse (RN) on duty for 8 consecutive hours per day for 6 days during the months of April and May of 2024 with the potential to affect 32 of 32 residents residing at the facility.</p> <p>Findings include:</p> <p>The Director of Nursing (DON) provided the daily schedules for April 2024 until May 24, 2024. The following dates were noted without RN coverage for 8 consecutive hours:</p> <p>4/13/24, 4/14/24, 4/27/24, 4/28/24, 5/11/24, &amp; 5/12/24.</p> <p>An interview conducted with the DON, on 5/23/24 at 9:52 a.m., indicated there were no RN hours that consisted of 8 consecutive hours for the days listed.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>30344</p> <p>Based on interview and record review, the facility administered a resident his antipsychotic medication in excessive dosage for 1 of 5 residents reviewed for unnecessary medication. (Resident H)</p> <p>Findings include:</p> <p>The clinical record for Resident H was reviewed on 5/21/24 at 1:50 p.m. His diagnoses included, but were not limited to, psychotic disorder with delusions, major depression, and dementia.</p> <p>The psyche (psychiatric/psychological) services care plan, revised 6/23/23, indicated he received services through the facility's provider related to major depression, psychotic disorder, and dementia. An intervention was medication management though the facility's provider.</p> <p>An interview was conducted with Family Member 11 on 5/21/24 at 1:57 p.m. She indicated she thought Resident H was receiving too many psychotropic medications at the facility. He had a medication change regarding one of his antipsychotic medications earlier this year, but the facility never notified her of the change.</p> <p>The 2/9/24 psyche note read, Resident has a history of delusions and agitation, none noted today. Continue Risperdal 0.5 mg twice daily. Continue to monitor for new or worsening delusions or behaviors.</p> <p>The 2/9/24 physician orders indicated to administer two 0.25 mg tablets (0.5 mg total) of Risperdal two times a day, starting 2/9/24.</p> <p>The electronic health record indicated Resident H received 0.5 mg of Risperdal 3 times a day between 2/10/24 and 2/15/24.</p> <p>An interview was conducted with the DON on 5/23/24 at 12:52 p.m. She indicated there was no verification the facility notified Family Member 11 of Resident H's 2/9/24 Risperdal medication change. They probably called Family Member 11 to inform her, but she was likely unavailable, and the call was not documented.</p> <p>The 2/16/24 Note To Attending Physician/Prescriber indicated Resident H had been taking Risperidone 0.75 mg in the morning and 0.5 mg in the evening. On 2/9/24, a provider progress note indicated a plan to decrease Risperidone to 0.5 mg BID (twice daily.) The 0.75 mg morning order was discontinued and a new order for 0.5 mg twice daily was added, but the existing 0.5 mg evening order remained active in the facility's electronic health record. This resulted in a current dose of 0.5 mg three times daily which was not intended. Recommend immediate update of [name of electronic health record] orders to match provider intended order of 0.5 mg BID. The 2/23/24 physician/prescriber response section of the note read, Risperdal dose corrected to 0.5 mg bid.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the DON (Director of Nursing) on 5/24/24 at 11:11 a.m. She indicated on 2/9/24 she entered a new Risperdal order of 0.5 mg twice daily, discontinued the 0.75 mg morning order for Risperdal, but did not discontinue the 0.5 mg evening order of Risperdal. The 2/9/24 Risperdal change should have been a decrease, but in error, it was an increase.</p> <p>The Use of Psychotropic Medication policy was provided by the DON on 5/24/24 at 12:57 p.m. It read, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).</p> <p>3.1-48(a)(1)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45291</p> <p>Based on observation, interview, and record review, the facility failed to properly store a medicated cream for 1 of 1 residents reviewed for medications at the bedside (Resident D) and failed to ensure the medication carts did not contain expired insulin for four residents for 2 of 2 medication carts observed. (Residents 1, 2, 4 and 8)</p> <p>Findings include:</p> <p>1. The clinical review for Resident D was completed on [DATE] at 11:15 a.m. The medical diagnosis included a history of stroke.</p> <p>An Annual MDS Assessment, dated [DATE], indicated Resident D was cognitively intact.</p> <p>An observation on [DATE] at 12:14 p.m. indicated a container of medicated cream with a pharmacy label for Resident D was being stored on an open front white shelf above the television stand in Resident D's room.</p> <p>An observation on [DATE] at 12:40 p.m. indicated the container of medications cream with a pharmacy label for Resident D remained on the while shelf in Resident D's room.</p> <p>An observations and interview with LPN 2 on [DATE] at 12:46 p.m. indicated the container of medications cream with a pharmacy label for Resident D was on the shelf in Resident D's room. LPN 2 confirmed this was a currently ordered medicated cream for Resident D, the container was open, and should not be stored in Resident D's room. LPN 2 then removed the cream from Resident D's room.</p> <p>36942</p> <p>2. An observation was conducted of a medication cart with Licensed Practical Nurse (LPN) 3 on [DATE] at 9:10 a.m. There was Humalog (fast acting insulin) for Resident 2 with the bottle dated for [DATE]. LPN 3 indicated Resident 2 doesn't receive the sliding scale insulin that often.</p> <p>An observation was conducted of another medication cart with LPN 2 on [DATE] at 9:20 a.m. There was bottle that contained Fiasp injection (fast acting insulin) with a date of [DATE] for Resident 1. There was a bottle that contained insulin lispro (fast acting insulin) for Resident 8 that was dated for [DATE]. There was a bottle that contained Novolog (fast acting insulin) for Resident 4 dated for [DATE] and a bottle that contained Lantus (long-acting insulin) dated for [DATE]. LPN 2 indicated when she opened the bottles where the insulin was stored in, the vials had dates consistent with the dates listed on the bottles.</p> <p>An interview conducted with DON, on [DATE] at 3:07 p.m., indicated the pharmacy came out last month and audited the medication carts. The pharmacy conducted audits monthly. The night shift staff conducted audits of the medication carts as well.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/24/2024
NAME OF PROVIDER OR SUPPLIER  Majestic Care of McCordsville		STREET ADDRESS, CITY, STATE, ZIP CODE  7476 W Lane Rd McCordsville, IN 46055	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A policy titled Medication Storage, undated, was provided by the Director of Nursing (DON) on [DATE] at 1:32 p.m. The policy indicated the following, .1. General Guidelines .a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls .b. Only authorized personnel will have access to the keys to locked compartments .3. External products: Disinfectants and drugs for external use are stored separately from internal and injectable medications .8. Unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels</p> <p>3XXX,d+[DATE](o)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/24/2024
NAME OF PROVIDER OR SUPPLIER  Majestic Care of McCordsville		STREET ADDRESS, CITY, STATE, ZIP CODE  7476 W Lane Rd McCordsville, IN 46055	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45291</p> <p>Based on observations, interview, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP) for 1 of 5 residents reviewed for infection control. (Resident D)</p> <p>Findings include:</p> <p>1. The clinical review for Resident D was completed on 5/22/2024 at 11:15 a.m. The medical diagnoses included history of a stroke and overactive bladder.</p> <p>An Annual MDS Assessment, dated 4/16/2024, indicated Resident D was cognitively intact and utilized an indwelling urinary device.</p> <p>A care plan, dated 3/28/2024, indicated to utilized a gown and gloves during high contact care with Resident D.</p> <p>A physician order, dated 12/29/2023, indicated Resident D had an indwelling urinary device in the form of a suprapubic catheter.</p> <p>A physician order, dated 3/27/2024, indicated to utilize enhanced barrier precautions during high contact care activity with Resident D.</p> <p>An observation started on 5/21/2024 at 12:13 p.m., indicated CNA 4 and CNA 5 providing Resident D with a bed bath, catheter care, and transfer. Resident D had an indwelling suprapubic urinary catheter. Both CNAs utilized universal precautions of disposable gloves during the care, but neither utilized the enhance barrier precautions of a gown.</p> <p>An interview with CNA 5 on 5/21/2024 at 1:11 p.m. indicated that they usually use enhanced barrier precautions of gloves and gown when providing direct care to Resident D, but it had slipped both her and the other CNA's mind.</p> <p>A policy entitled, Enhanced Barrier Precautions, was provided by the Director of Nursing on 5/21/2024 at 3:15 p.m. The policy indicated that the facility would utilize EBP for residents with indwelling medical devices, including urinary catheters. EBP included the utilization of gown and gloves during high contact resident care, including bathing, transferring, and device care.</p> <p>3.1-18(a)</p>		