STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 00 B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00426598, IN00427289, and IN00427034. Complaint IN00426598- Federal/state deficiencies related to the allegations are cited at F812. Complaint IN00427289- Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00427034- No deficiencies related to the allegations are cited. Survey dates: February 1 & 2, 2024. Facility number: 011049 Provider number: 155670 AIM number: 200258520 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 6 Medicaid: 66 Other: 18 Total: 90 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 8, 2024.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective February 14, 2024, to the complaint survey completed on February 2, 2024. We respectfully request a paper review and will provide any additional information requested.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Thompson	Executive Director	02/14/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents fall interventions were in place to prevent a fall for 1 of 3 resident reviewed for falls. (Resident E) Finding includes: On 2/2/24 at 9:05 a.m., Resident E was observed in his room in bed eating breakfast. Resident E indicated he had no concerns with his care except sometimes when he wants up for the day it takes staff awhile to come help him. Resident E indicated he feels he is independent and tried to get up and fell recently. Resident E's electric wheelchair was observed in his room in the vicinity of his bed. On 2/2/24 at 9:13 a.m., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified sequel of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction. A Quarterly MDS (Minimum Data Set) dated 11/23/23 indicated Resident E's cognition was intact, limited range of motion impairment upper and lower one side, mobility device electric wheelchair, bed mobility extensive assist x 2, transfer extensive assist x 1.	F 0689	**F689 Accidents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E's fall care plan was reviewed, and interventions were updated and audited for accuracy. CNA assignment sheets audited and updated according to the care plan. Staff education completed on location of fall intervention information. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents with falls in the last 30 days have been reviewed for appropriate fall interventions and care plan interventions updated as needed. All current fall interventions were audited per DNS/Designee to ensure plan of care is followed on	02/14/2024

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	Care plans were reviewed and included, but were not limited to: [name] is at risk for falls or fall related injury r/t history of falls, poor safety awareness, incontinence, balance problems, staff assistance required for transfers. 11/5/23 resident is non-compliant with asking for and waiting for staff assistance for slide board transfers when he chooses to use it , date initiated 9/16/23, revision on 12/8/23. Interventions included, but were not limited to: 1/24/24: wheelchair to be removed from room when he isn't in it to encourage him to ask for staff assistance for transfers, date initiated 1/29/24. Progress notes were reviewed and included, but were not limited to the following : 12/30/23 at 6:26 a.m., " Res noted to be insistent on self-transferring from bed to wheelchair, CTM at standby d/t weakened condition. Res unsuccessful with transfer and landed in upright sitting position between wheelchair and bed CTM witnessing unable to reach res due to angle. CTM then alerted writer, resident was assisted back into bed via gait belt. res was dry with appropriate footwear. immediate intervention to remove wheelchair from bedside while in bed to encourage assistance. ADON notified, wife notified. and np (Nurse Pracitioner) notified." 12/30/23 2:10 p.m., Late entry: " IDT fall follow up on 12/30/23. Resident transferring self, unassisted, and fell. Staff present, resient (sic) indicated he is able to do it and refused any assistance with transfer assistance despite education. Resident currently has Pne (pneumonia) and increased SOA/Weakness, and should be on oral ATB, resident is refusing medications. Education has		2/5/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on fall prevention and interventions on 2/8/24 by DNS/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool fall care plan audit will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	been provided to resident and family. Resident has no injuries, vitals and assessment completed. NP, DNS, Wife notified. New intervention is therapy eval." 1/11/24 11:20 a.m., " Resident has self transfer self from bed to chair. called Rp (sic) (representative) pending call back" 1/21/24 at 3:30 a.m., " Res. room mate alerted staff that res. was on the floor. Staff entered room to find res. lying on his L side between his bed and w/c. Res. bed was up high. noted to have 3 sm. abrasions to L knee. Res. denies pain. AROKM done to all 4 ect. without diff. Skin check done and no further injuries found. Res. stated he raised the bed up high because he didn't want to us the hoyer so he raised the bed above his chair so he could attempt to fall into the chair and missed. Res. moved from floor to bed with assist of 3 and hoyer lift. Neuro-checks initiated and WNL for res. Spoke with res. re: importance of calling for help with the call light and allowing staff to use hoyer lift for transfers." 1/22/24 1:24 p.m., Late entry: " IDT met to review fall on 1/21. Resident refused to use hoyer lift, raised his bed so he could " fall into his chair, and missed." Resident has been educated on the importance of using the lift or slide board for transfers and allowing staff toassist. (sic) Resident adamantly refuses to use either and will not call for assistance for transfers. IDT has chosen to implement intervention for resident's chair to be removed from room when he isn't in it to encourage resident to ask for staff assistance for transfers." 1/26/24 2:44 p.m., " INITIAL CAR : IDT met to review resident for falls. Resident had fall on 1/21			

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	when he refused to use the hoyer lift, raised his bed up so that he could " fall into his chair, and missed" . Resident has been educated on the importance of using the lift or slide board for transfers and allowing staff to assist, however he adamantly refuses to use either and will not call for assistance for transfers. IDT has chosen to implement intervention for resident's chair to be removed from room when he isn't in it to encourage resident to ask for staff assistance for transfers. IDT will continue to follow. " 1/27/24 6:10 p.m., Late entry: Res. found on floor in his room between his bed and w/c. AROM done to all 4 ext. without diff. No injures noted. Res. denies hitting head. Res. stated that he did not hit the call light and ask for help cause he doesn't like the hoyer lift. REs. (sic) helped up with A4 (sic) and hoyer. Res. placed back in bed and w/c removed from room and res. given call light and reminded to use call light when he wants to get up out of bed." On 2/2/4 at 9:43 a.m., Nurse 1 indicated they they had provided care to Resident E, off the top top of their head fall interventions in place were no skid footwear, bed low, belt in power chair, normally fall interventions pop up on the TAR (Treatment Administration Record). On 2/2/24 at 8:40 a.m., the ADON indicated she does rounding to ensure fall and pressure interventions are in place, the nurse on the unit is responsible to ensure they are in place. On 2/2/24 at 9:45 a.m., Resident E's wheelchair was observed to still be in the room, Resident E was lying in bed. On 2/24/24 at 9:49 a.m., CNA 1 indicated they			

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	provided care to Resident E once in awhile, were not sure what fall interventions were in place, but it should be on the CNA assignment sheet. On 2/2/24 at 12:13 p.m., the Administrator provided the current policy on fall management with a original date of October 2019. The policy included, but was not limited to: ...2. A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. Care plan including interventions and fall risks will be reviewed at least quarterly. 3. The resident specific care requirements will be communicated to the assigned caregiver utilizing the Kardex... This citation relates to Complaint IN00427289. 3.1-45(a)(1)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the			

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	facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored, and served in a sanitary manner for 2 of 2 kitchen observations. The kitchen floors had debris build up, equipment was soiled, and food was open to air and undated. (Kitchen) Finding includes: On 2/1/24 at 8:19 a.m., the kitchen was observed to have the following: 1. Floor debris build up, including along the edges of the the walls, under storage racks, behind the stove, and warmers, under the dish machine, the area where cleaning supplies and mops were stored. 2. In the walk in cooler a partially used open log of ground hamburger wrapped in foil, a plastic bag with part of a cucumber, plastic bag with sliced tomatoes, were observed with no dates. 3. In the walk in freezer a bag of chicken tenders, bag of hashbrowns, bag of ravioli, were open to air and undated. A bag of hamburger patties were undated. 4. The top of ovens soiled. On 2/1/24 at 11:37 a.m., the same was observed except the bag of hamburger patties were gone. On 2/2/24 at 11:45 a.m., the Dietary Manager	F 0812	**F 812 Food Procurement** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents experienced any negative outcomes as a result of the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. Kitchen sanitation and storage will be completed daily. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All dietary staff was educated on Labeling and Dating to ensure that all food is properly stored with appropriate labeling by the Dietary Manager on 2/6/2024 and ongoing. Implemented food labeling and storage policy to ensure proper food procurement. All dietary staff was educated on kitchen sanitation to ensure sanitary service by the Dietary	02/14/2024

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	indicated the floors were cleaned on January 4th, including behind the equipment by housekeeping, she came in and helped, they are ordering a stronger cleaner to help remove soil. The chicken tenders, hash browns, and hamburger had been thrown away, a new staff member had left the food undated. On 2/2/24 at 12:15 p.m., kitchen cleaning schedules were reviewed and included, but were not limited to: Do daily: AM cook: stove top and stove, clean stove top, backsplash, and sides of stove, clean glass ovens. PM aide: Walk-in cooler date and label all products and clean floor & racks. Breakfast cook: sweep and mop serving line area. PM Aide #1: sweep and mop dish room area. On 2/2/24 at 12:13 p.m., the Administrator provided the current policy on environment with a revision date of 9/2017. The policy included, but was not limited to: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. On 2/2/24 at 12:13 p.m., the Administrator provided the current policy titled "Receiving". The policy had a revision date of 2/2023, and included but was not limited to, ...all food items will be appropriately labeled and dated either through manufacturer packaging or staff notation... This citation relates to Complaint IN00426598.		Manager on 2/6/2024 and ongoing. Implemented new sanitation task lists to ensure kitchen sanitation is maintained. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Labeling and dating audit will be completed daily X 4 weeks, weekly X 4 weeks and monthly X 4 months by DM/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. QAPI tool Cleaning Schedule Audit will be completed daily x 4 weeks, weekly x 4 weeks and monthly x 4 months by the DM/Designee. If 100% threshold is not achieved, an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	3.1-21(i)(2) 3.1-21(i)(3)			