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	07/19/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434521, IN00437811, IN00435625, IN00435208, IN00435670, IN00438538, IN00438603, IN00438441. Complaint IN00434521- Federal/State deficiencies related to the allegations are cited at F659. Complaint IN00437811- Federal/State deficiencies related to the allegations are cited at F659. Complaint IN00435625- Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00435208- No deficiencies related to the allegations are cited. Complaint IN00435670- No deficiencies related to the allegations are cited. Complaint IN00438538- No deficiencies related to the allegations are cited. Complaint IN00438603- No deficiencies related to the allegations are cited. Complaint IN00438441- No deficiencies related to the allegations are cited. Survey dates: July 15, 16, 17, 18, 19, 2024. Facility number: 011049 Provider number: 155670 AIM number: 200258520 Census Bed Type: SNF/NF: 89 Total: 89	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 August 7, 2024, to the complaint survey completed on July 19, 2024. We respectfully request a paper review and will provide any additional information requested.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Thompson	Executive Director	08/08/2024

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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	Census Payor Type: Medicare: 2 Medicaid: 68 Other: 19 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 25, 2024.			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed. A resident was given a straw to drink with, and hand splints were not applied. (Resident B) Findings include: On 7/15/24 at 10:30 a.m., an observation of wound dressing changes were observed for Resident B. Resident B's hand's were contracted, no hand splints were observed on. A sign was observed above the bed indicating no straws to be used. On 7/15/24 at 10:53 a.m., observation of morning care was observed on Resident B, no hand splints were applied. On 7/15/24 at 1:18 p.m., Resident B's clinical record	F 0659	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B's diet orders, adaptive equipment orders and care plans were reviewed and special orders were updated and added to the profile alerts. CNA assignment sheets audited and updated according to the care plan with resident specific special orders. Staff education completed on location of special-order alerts and any adaptive equipment needs. **How other residents having the potential to be affected by the same deficient practice will be**	08/07/2024

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	was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified osteoarthritis unspecified site. A Quarterly MDS (Minimum Data Set) assessment dated 5/14/24, indicated Resident B's cognition was intact, functional limitations in range of motion, upper and lower extremities, impairment both sides, self- care- eating, dependent. Care plans included, but were not limited to: (Resident B) needs assistance with activities of daily living r/t left hemiplegia, wounds. Interventions included, but were not limited to: Per therapy recommendation: apply resting hand splints to bilateral wrist/hand in the morning for up to 4 hours and afternoon for up to 4 hours. Remove splints during meals and at bedtime. Check skin for any redness every shift. Wife noted to be non-compliant with diet, thickened fluids, and recommendation no straws be used; education provided r/t risks of adverse reactions to non-compliance. Wife noted to use PEG tube for feeding at times as she did at home; Nursing provided education r/t proper technique. Date Initiated: 2/14/2024, revision on: 2/27/2024 Current physician orders for July 2024 were reviewed and included, but were not limited to: Per therapy recommendation: Apply resting hand splints to bilateral wrist/hand in the morning for up to 4 hours and afternoon for up to 4 hours. remove splints during meals and at bedtime. Check skin for any redness, every shift, order date 3/22/24. Regular diet, Dys(dysphagia) puree texture, nectar thickened liquids consistency, no straws, order date 2/13/24.		**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. 100% special diet order audit completed 8/2/24 to ensure all special orders listed in diet orders were updated to the profile alerts and added to the CNA assignment sheets. 100% adaptive equipment audit completed for accuracy and added/removed from the CNA assignment sheets. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on following physician orders/plan of care and on accurate documentation by the DNS/designee on 8/6/24. **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 Order audit will be completed weekly x 4 weeks, bimonthly 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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	The July 2024 EMAR (Electronic Medication Administration Record) was reviewed. July 1- 19th were signed by the nursing staff as done for the hand splints. No refusals were observed in the clinical record. On 7/17/24 at 8:17 a.m., RN 1 was observed to administer Resident B his medications. RN 1 was observed to put a straw in a cup of orange juice and give to Resident B to swallow his medications. A sign was observed above Resident B's bed that indicated no straws to be used. No hand splints were observed on. On 7/17/24 at 1:41 p.m., Resident B was observed in the dining room sitting in a wheelchair, no hand splints were observed on and no meal was being served. On 7/19/24 at 8:04 a.m., a cup of water was observed on the bedside table with a lid and straw in the lid. A cup with an amber liquid was observed with no lid, a straw was in the cup. Both liquids were not thickened. The table was not in reach of Resident B at the time of observation. On 7/19/24 at 9:10 a.m., RN 1 indicated Resident B's diet order was puree food, thickened liquids, regular diet. She was unaware there was an order for no straws, she had noticed liquids sitting on Resident B's bedside table that were not thickened. On 7/19/24 at 11:44 a.m., Resident B was observed up in a wheelchair being propelled down the hallway by a staff member, no hand splints were observed on and no meal was being served at that time. On 7/19/24 at 11:45 a.m., CNA 1 indicated Resident			

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	B had hand splints on in the past, it was not on the current CNA assignment sheet, she had not observed hand splints on Resident B recently and not applied them when she provided care. On 7/19/24 at 11:48 a.m., RN 1 indicated she worked on the unit Monday, Wednesday, and Friday, and was not aware Resident B had an order for hand splints. 7/19/24 at 11:58 a.m., RN 1 indicated Resident B's hand splints were in a drawer in his room, herself and a CNA had just tried to apply the splints and Resident B shook his head no for refusal. On 7/19/24 at 11:55 a.m., the Administrator provided the current policy on comprehensive care plans with an effective date of 1/2/24. The policy included, but was not limited to: ...7. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made... The facility did not provide a policy on following physicians orders. This citation relates to Complaint IN00434521 and IN00437811. 3.1-35(g)(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			

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	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record 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, and equipment was soiled. (Kitchen) Findings include: On 7/15/24 at 8:55 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 and tables, behind the stove, and warmers, under the dish machine, three compartment sink, under the steam table. The dry pantry floor had debris build up on floors, under racks, condiment packets observed on the floor and under the food racks. 2. Debris build up on the sides of the stove, the shelf above the stove, shelves on the stainless	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. A full kitchen deep sanitation completed on 7/20/2024. **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 cleaning schedule will be completed daily. **What measures will be put into**	08/07/2024

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	steel table the steamer was sitting on, top of steamer. The same was observed on 7/16/24 at 11:40 a.m. On 7/16/24 at 2:00 p.m., kitchen cleaning schedules were reviewed and included, but were not limited to: AM cook: 3 compartment sink- please clean outside and the floor underneath. AM cook : stove top & stove- clean stove top, backslash, and side of stove, clean gas ovens. PM cook & servers: floor/walls- clean and sanitize shelves, walls, and floors. On 7/10/24 at 12:04 p.m., the District Dietary Manager indicated daily the floor is swept and spot mopped during the day, every night the floor is fully swept and mopped. On 7/19/24 at 11:35 p.m., the Administrator provided the current policy on food environment for the kitchen, with a revision date of 2/23. The policy included, but was not limited to: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Procedures: 1. The Dining Service Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation...4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces... This citation relates to Complaint IN00435625. 3.1-21(i)(2) 3.1-21(i)(3)		**place and what systemic changes will be made to ensure that the deficient practice does not recur;** All dietary staff was educated on cross contamination and sanitation and cleanliness with return demonstration by the District Dietary Manager on 7/20/2024 and ongoing. Implemented new sanitation task lists to ensure kitchen sanitation is maintained. Purchased suction cups for safe dish handling. **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 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.	