STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(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 Complaints IN00394434, IN00392739, and IN00392475. Complaint IN00394434- Substantiated. Federal/State deficiency related to the allegations is cited at F636. Complaint IN00392739 - Unsubstantiated due to lack of evidence. Complaint IN00392475 - Substantiated. No deficiencies related to the allegation is cited. Survey dates: November 16, 17, and 18, 2022 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 5 Medicaid: 88 Other: 14 Total: 107 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 30, 2022.	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of December 19, 2022.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Mollenhoff	Director of Nursing Services	12/19/2022

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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	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care			

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	staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on interview and record review, the facility failed to provide appropriate care plan interventions for a severely cognitively impaired resident related to a safe environment by providing supervision during meal time for 1 of 3 resident reviewed. (Resident C) Findings include: The clinical record for Resident C was reviewed on 11/16/22 at 11:28 a.m. The diagnoses included, but were not limited to, dementia with behaviors and malignant neoplasm of pharynx. A 5-day MDS (Minimum Data Set) assessment, dated 9/18/22, indicated the resident was severely cognitively impaired, had clear speech, was rarely/never understood, and rarely/never understands others. The resident required one physical staff member's assistance for mobility, transfer, and ADLs (Activities of Daily Living).	F 0636	Survey Event ID: 9Y9L11 Cycle Start Date: 11/18/22 **F636 – Comprehensive Assessments & Timing** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident C was identified during the time of observation. Resident C did not reside in the facility at time of observation. All staff were educated on providing supervision during mealtime. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents with a	12/19/2022

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	A Physician's Order, dated 9/14/22, indicated the resident was to receive a pureed texture, thin consistency diet. A Progress Note, dated 10/3/22 at 8:37 p.m., indicated the nurse entered Resident C's room at 8:37 p.m. and the resident was unresponsive. The nurse could not palpate a pulse. The nurse called for help, a second nurse arrived, and CPR (Cardio Pulmonary Resuscitation) was immediately started, a crash cart was obtained, at 8:42 p.m., 911 was called. CPR was continued until EMS (Emergency Medical Services) arrived at 8:50 p.m. EMS worked on the resident until 9:11 p.m., when the time of death was called. The DON (Director of Nursing) was notified, the resident's POA (Power of Attorney) was notified, and the coroner removed body from facility. An EMS (Emergency Medical Services) report, dated 10/3/22 at 8:43 p.m., indicated the resident was supposed to be a pureed liquids, however the patient was found with hamburger in her mouth and vomit. A Progress note, dated 9/29/22 at 3:41 p.m., indicated the resident was non-compliant with her mechanically altered diet. The resident was witnessed at the vending machine at that time. POA (Power of Attorney) and the NP (Nurse Practitioner) was made aware of non-compliance with the diet. A Progress note, dated 7/6/22 at 9:40 a.m., indicated the resident was observed on that date purchasing items out of the vending machine. The items in the vending machine were non-complaint with her mechanically altered diet. SSD (Social Service Director) offered education on the importance of following her prescribed diet. The		mechanically altered diet have the potential to be affected by this practice. 2. A campus wide review was completed to review all Residents with a mechanically altered diet. All identified residents with a mechanically altered diet were screened for supervision during mealtime. Care plans audited for cognitively impaired residents receiving mechanically altered diets to ensure appropriate interventions to provide a safe environment during and after mealtimes. These findings were discussed in IDT. Campus provided education to nursing staff on mechanically altered diet and supervision during and after mealtime. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DHS or Designee will complete an audit for all new diet orders and supervision during mealtimes weekly x4 weeks, then monthly ongoing to ensure residents with a mechanically altered diet are identified and supervision during mealtime screenings are provided in a timely manner. This plan will be revised as warranted. 2. DHS or Designee will perform random observations of mealtimes (breakfast, lunch,	

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	resident voiced understanding. A Care Plan, initiated on 7/7/22, indicated Resident C exhibited behavior symptoms of non-compliant with mechanical altered diet AEB (as evidenced by) purchasing items out of the vending machine. The interventions, dated 7/7/22, were to educate the resident and POA on the importance of following the prescribed diet as ordered and to maintain a safe environment for the resident. A Speech Therapy Note, dated 7/1/22, indicated Resident C had clinical signs and symptoms of possible aspiration and was at risk for aspiration with puree foods. The recommended level of skill therapy services was required due to the resident had difficulty learning new information. The resident agreed to puree foods. The Week one Menu was provided by the DON on 11/16/22 at 12:25 p.m. Some of the alternate menu items available were a hamburger or a cheeseburger. During an interview on 11/18/22 at 11:28 a.m., the DON indicated she was not in the building at the time of the incident. She received a call from Agency Nurse 2 that was on duty. The nurse indicated she had found Resident C cold and nonresponsive. The resident was a full code and CPR was initiated. Agency CNA (Certified Nursing Assistant) 3 was on the floor prior to the incident. The food cart sat in the hallway and staff were busy with other residents. She saw Resident C putting her food tray in the cart as normal. Resident C had a roommate Resident H. Resident C also often returned her roommates meal tray to the cart. Resident C was fiddling in the food cart and CNA 3 checked on her. The CNA saw both		and/or dinner) 3x weekly x4 weeks, 2x weekly x4 weeks, and monthly ongoing. This plan will be revised as warranted. 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? 1. For quality assurance, the DHS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 95% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of December 19, 2022.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

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	resident's meal trays on the cart. The CNA did not see anything in the resident's hand. Agency Nurse 2 found Resident C cold and not responding and called a Code. The resident was non-compliant with her diet prior to the incident. On 10/3/22 there were three NPs who visited with Resident C. The resident was difficult to understand. The resident was "not right" that day and had been declining. There were no sandwiches in the vending machine, only snack cakes, chips, and candy. The menu that night was cheesy cheque and hamburger was alternative, but she had no idea if any hamburgers were served that night. During the interview on 11/18/22 at 11:35 a.m., the DON indicated she was notified Resident C had a fully intact piece of hamburger in her mouth, and when she asked the staff where the resident got that, and they did not know. The hamburger was on the tip of her mouth, not blocking the air way. During her investigation there was no food brought into the facility on the night of the incident. She had no idea how the resident received a hamburger. The current facility policy titled "Care Planning-Interdisciplinary Team," and dated 9/28/2017, was provided by the DON on 11/18/22 at 1:40 p.m. The Policy indicated, " ...Interdisciplinary Teas was responsible for the development of an individualized comprehensive care plan for each resident ..." The current facility policy titled "Menus and Adequate Nutrition," and dated November 2017, was provided by the DON on 11/18/22 at 1:40 p.m. The Policy indicated, " ...the purpose was to assure menus were developed and prepared to meet resident ...needs ..."			

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	The current facility policy titled "Accidents and Supervision," and dated October 2022, was provided by the DON on 11/18/22 at 1:40 p.m. The Policy indicated, " ...Each resident will receive adequate supervision ...to prevent accidents ...3. Implementing interventions to reduce hazards ...Definitions: Accident refers to any unexpected or unintentional incident, which results in injury ...Supervision/Adequate Super vision refers to intervention and means of mitigating risk of an accident ...The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents ...3. Implementation of Interventions - using specific interventions ... to reduce resident's risks ...e. ensuring that the interventions are put into action ...5. Supervision ...is an intervention and a means of mitigating accident risk ..." This Federal tag relates to Complaint IN00394434. 3.1-31(e)			