STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00436424, IN00436425 and IN00436426 Complaint IN00436424 - No deficiencies related to the allegations are cited. Complaint IN00436425 - No deficiencies related to the allegations are cited. Complaint IN00436426 - No deficiencies related to the allegations are cited. Survey dates: July 23, 24, 25, 26, & 29, 2024. Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 2 Medicaid: 64 Other: 17 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 2, 2024.	F 0000	Please accept the following Plan of Correction as our credible submission of compliance. We respectfully request a desk review in lieu of a post survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matt Elwell	HFA	08/09/2024

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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F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to provide fresh fluids and keep fluids within reach for 3 of 3 residents reviewed for hydration (Resident 54, Resident 18 and Resident 1). Findings include: 1. During an observation, on 7/24/24 at 11:36 a.m., Resident 54 was lying in bed, the resident had a 1/4 a cup of juice on the bedside table, the table was across the room out of reach of the resident, and the resident did not have any water in his room. During an observation, on 7/25/24 at 10:54 a.m., Resident 54 was lying in bed, the resident had no water or any type of fluids in his room. During an observation, on 7/25/24 at 12:53 p.m., Resident 54 was lying in bed, the resident had no water or any type of fluids in his room. During an observation, on 7/26/24 at 11:47 a.m., Resident 54 was lying in bed, the resident had a Styrofoam cup with ice water in it on the bedside table, the table was across the room and out of the resident's reach. Review of the record of Resident 54, on 7/29/24 at	F 0558	1 F**558 Actions taken for resident affected.** Immediate action(s) taken for resident #54, 18, and 1 **Resident # 54 & #18 was assessed by Director of Nursing Services for hydration needs. None identified during this time. Resident #1 is deceased** 2. **Identification of other residents having the potential to be affected was accomplished by:** All residents residing on the Advance Dementia Unit have the potential to be affected. 100% audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident had hydration available in room and within reach. No further concerns were identified.	08/12/2024

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	11:28 a.m., indicated the diagnoses included, but were not limited to, Alzheimer's disease, dementia, seizure disorder, anxiety disorder and hypokalemia. The July 2024 physician recapitulation for Resident 54 indicated the resident was ordered thin liquids. The plan of care for Resident 54, dated 3/15/22, indicated the resident had a history of urinary tract infections. The interventions included, but were not limited to, encourage fluids. 2. During an observation, on 7/23/24 at 12:40 p.m., Resident 18 did not have any fluids available in his room. During an observation, on 7/24/24 at 11:40 a.m., Resident 18 did not have any fluids available in his room. During an observation, on 7/25/24 at 10:52 a.m., Resident 18 did not have any fluids available in his room. During an observation, on 7/26/24 at 11:44 a.m., Resident 18 had a Styrofoam cup of ice water in his room. Review of the record of Resident 18, on 7/29/24 at 10:38 a.m., indicated the resident's diagnoses included, but were not limited to, schizophrenia, hypertension, major depressive disorder, Alzheimer's disease, dementia and moderate intellectual disabilities. The July 2024 physician recapitulation for Resident 18 indicated the resident was ordered thin liquids.		3. **Actions taken/systems put in place to reduce the risk of future occurrence** **Include:** QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager one and two also present Social Services for Memory Care units and Social services #2 to review the plan and findings. This action was completed by the Executive Director on 7/30/20244. On 8/5/24, education was initiated and will continue until all RN/LPN/Nursing & Activity care team members have been educated on ensuring that residents are offered fluids throughout the day on the Advanced Dementia Unit and are within reach. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, Weekend Supervisor, Unit Managers. Completed on 08/12/2024 4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit documentation for offering	

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	3. During an observation, on 7/25/24 at 11:00 a.m., Resident 1 was lying in bed and the resident had no fluids available in her room. During an observation, on 7/26/24 at 11:49 a.m., Resident 1 was lying in bed and had no fluids available in her room. The resident indicated she was "lucky" if she received one cup of ice water a day. Review of the record of Resident 1, on 7/25/24 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, dementia, diabetes, atherosclerotic heart disease, major depressive disorder, paranoid personality disorder, and conversion disorder with seizures. . The Annual Minimum Data Set assessment for Resident 1, dated 4/4/24, indicated the resident was cognitively intact for daily decision making. The resident hydration policy provided by the Director of Nursing, on 7/29/24 at 1:15 p.m., indicated the facility would strive to provide adequate fluids. The Nurse aides would provide and encourage of bedside fluids on a routine basis as part of daily care. 3.1-3(v)(1)		fluids through the day & ensure that hydration is within reach. The audit will be conducted weekly x 3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time consistent substantial compliance has been achieved as determined by committee. Audit results will be shared with QAPI. QAPI meeting 07/30/24 was held with the Executive Director, MDS, Social Services, Memory Care Unit Coordinator, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI will be held on 8/22/24. Audited records will be reviewed by the Risk Management/ Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee 5. Corrective action complete date: 08/12/24	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving			

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	treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to provide a homelike	F 0584	F584 **What corrective action will be accomplished for those**	08/12/2024

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	environment for 5 of 7 residents reviewed for environment (Resident 18, Resident 1, Resident 75, Resident 38, and Resident 64). Findings include: 1. During an observation, on 7/23/24 at 12:40 p.m., Resident 18's bedroom was bare. The resident had no personal belongings and no pictures. The resident had a broken clock on the wall. During an observation, on 7/25/24 at 10:52 a.m., Resident 18's bedroom was bare. The resident had no personal belongings and no pictures. The resident had a broken clock on the wall. Review of the record of Resident 18, on 7/29/24 at 10:38 a.m., indicated the diagnoses included, but were not limited to, schizophrenia, hypertension, major depressive disorder, Alzheimer's disease, dementia, and moderate intellectual disabilities. The plan of care for Resident 18, dated 8/3/22, indicated the resident desired to remain in the facility long term. The interventions included, but were not limited to, encourage resident and family to create a familiar and homelike environment. The plan of care for Resident 18, dated 8/4/22, indicated the resident resided on a secured memory care unit due to diagnosis of dementia and benefits from specialized activity care programming. The resident had a diagnosis of Alzheimer's disease. The interventions included, but were not limited to, maintain the room as homelike as possible. 2. During an observation, on 7/23/24 at 12:44 p.m., Resident 1 was lying in bed. The resident had no pictures, a clock, or any personal items in her		**residents found to have been affected by the deficient practice.** Residents 1,18, 38, 64, and 75 rooms were all evaluated for alleged deficiencies related to citation F584 and corrected accordingly. **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. Administrator/Maintenance Director audited all facility rooms to identify any further deficiencies including anything in disrepair or not being homelike and corrected them if needed. **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur.** Administrator/Dept Heads educated all facility staff by 8/12/2024 on identifying and reporting any potential deficiencies in resident rooms including anything in disrepair or not being homelike so they can be corrected. Administrator/Dept Heads will round all rooms weekly to ensure any room deficiencies will be identified and corrected. QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of	

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	bedroom. Resident 1 indicated she did not like her bedroom. During an observation, on 7/25/24 at 11:00 a.m., Resident 1 was lying in bed. The resident had no pictures, a clock, or any personal items in her bedroom. Resident 1 indicated she "hated" her bedroom and did not feel like it was homelike. Review of the record of Resident 1, on 7/25/24 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease (COPD), dementia, diabetes, atherosclerotic heart disease, major depressive disorder, paranoid personality disorder, and conversion disorder with seizures. The plan of care for Resident 1, dated 4/13/22, indicated the resident resided on a secured memory care unit due to the diagnosis of dementia. The intervention included, but were not limited to, maintain the room as homelike as possible. . The Annual Minimum Data Set assessment for Resident 1, dated 4/4/24, indicated the resident was cognitively intact for daily decision making. During an observation and interview with the Social Service Director (S.S.D.), on 7/26/24 at 11:55 a.m., they agreed that Resident 18 and Resident 1's bedrooms were not homelike. The S.S.D. indicated it was Social Services, Nursing, and Marketing responsibility to ensure resident bedrooms were homelike. 3. The clinical record for Resident 75 was reviewed on 7/26/24 at 2:33 p.m. The medical diagnosis included bipolar disorder.		Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. The action was completed by the Executive Director on 7/30/24 **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.** Administrator/Dept Heads will audit rooms 3X weekly for 6 months to identify any deficiencies relating to resident rooms. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI meeting will be held on 8/22/24. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared by the Risk Management/Quality Assurance Committee.	

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	A Quarterly Minimum Data Set assessment, dated 7/4/24, indicated that Resident 75 was cognitively intact. During an observation and interview, on 7/23/2024 at 1:29 p.m., Resident 75 indicated that the blinds in her room had a large break on the right-hand side. A napkin was placed over the opening and per Resident 75 they have been broken for "some time". 4. The clinical record for Resident 38 was reviewed on 7/26/24 at 2:34 p.m. The medical diagnosis included COPD and stroke. A Quarterly Minimum Data Set Assessment, dated 6/10/24, indicated that Resident 38 was cognitively intact. During an observation and interview, on 7/23/24 at 12:30 p.m., Resident 38 indicated the over bed light does not work all the time and she has one light out in her bathroom. She demonstrated pulling the cord to her over bed light seven times before it turned on. The right side of the light over the sink the bathroom did not turn on. Resident 38 stated she had told multiple staff about the lights being out, but they have not been fixed. 5. The clinical record for Resident 64 was reviewed on 7/26/24 at 2:37 p.m. The medical diagnosis included heart failure. A Quarterly Minimum Data Set Assessment, dated 4/24/24, indicated that Resident 64 was cognitively intact. During an observation, on 7/24/24 11:05 a.m., the light over the sink in Resident 64's bathroom was			

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	noted to have unmatched paint and two holes on either side in the drywall. During a tour of the facility with the Administrator, on 7/26/24 2:38 p.m., indicated he was not aware of the issues as above for Resident 75, Resident 38, or Resident 64's room, but would have them addressed as soon as possible. A policy entitled, "Resident Rights", was provided by the Area Vice President of Clinical Services on 7/29/24 at 2:10 p.m. The policy indicated, "...The resident has a right to safe, clean, comfortable and homelike environment..." 3.1-19(f)(5)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review the facility failed to provide in room self-initiated activities for 1 of 3 residents reviewed for activities (Resident 1). Finding include: During an observation and interview with	F 0679	F679 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Social Services completed psychosocial assessment on resident 1 to ensure no negative	08/12/2024

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	Resident 1, on 7/23/24 at 12:44 p.m., they were lying in bed, awake, and staring at the ceiling. Their television was unplugged with no music, books, magazines, puzzles, daily chronicle, or any type of activity was available for the resident. The resident indicated she did not like her room. During an observation and interview with Resident 1, on 7/25/24 at 11:00 a.m., they were lying in bed, awake, and staring at the ceiling. Their television remained unplugged with no music, books, magazines, puzzles, daily chronicle, or any type of activity was available for the resident. The resident indicated she "hated" her room. The resident indicated she did not necessarily like to do activities with other people. So, she stayed to herself and did her own thing. The resident refused to tell the writer what her favorite activity was. Review of the record of Resident 1, on 7/25/24 at 11:50 a.m., indicated diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, dementia, diabetes, atherosclerotic heart disease, major depressive disorder, paranoid personality disorder, and conversion disorder with seizures. The Annual Minimum Data Set assessment, dated 4/4/24, for Resident 1 indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. It was very important for the resident to take care of her personal belongings and things. It was somewhat important to listen to music, keep up with the news, and do things with groups of people. It was very important for her to conduct a favorite activity and go outside. The plan of care for Resident 1, dated 9/14/23,		outcomes relating to the alleged deficiency. Activity staff providing in room activities to resident 1 daily. **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. Administrator/Activity Director completed Activity preference audit by 8/8/24 of all residents with no additional negative findings. **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur.** Administrator/Activity Director will educate activity staff on providing activities to all residents by 8/12/2024. Activity staff will be documenting when they provide the in-room activities daily or documenting refusals when activities are being offered to ensure compliance. QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. **How the corrective action(s)**	

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	indicated the resident preferred to be engaged in independent self-directed activities. The interventions included watching television, reading, provide daily chronical, respect resident's right to decline activity, praise resident's participation in activities and resident needs encouragement, and reassurance to participate in activity. During an interview with the Activity Director, on 7/26/24 at 2:20 p.m., indicated it was the Activity Aides responsibility to ensure Resident 1 had self-initiated activities available in her room. The Activity policy provided by the Director of Nursing, on 7/29/24 at 11:00 a.m., indicated the facility would provide an ongoing activity program to support residents in their choice of activities. Individual and independent activities would be designed to meet the interest of each resident, as well as support their physical, mental and psychosocial well-being. 3.1-33(a)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Audit tools and documentation will be reviewed by Administrator in monthly QAA meeting to ensure compliance. The daily provision of in room activities or refusal documentation audits will be reviewed by the QAPI Committee monthly until such time consistent with substantial compliance has been achieved as determined by the committee. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI meeting will be held on 8/22/24. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared by the Risk Management/Quality Assurance Committee.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to administer residents' medication as ordered; notify the physician of a weight gain, as ordered; clarify a resident's medication order; ensure a resident's compression stockings were in place, as ordered; and follow-up on a physician's order for gastrostomy tube removal for 1 of 1 resident reviewed for dialysis, 1 of 5 residents reviewed for unnecessary medication, 1 of 1 resident reviewed for edema, and 1 of 1 resident reviewed for tube feeding. (Residents 14, 45, 52, and 64) Findings include: 1. The clinical record for Resident 52 was reviewed on 7/26/24 at 2:15 p.m. His diagnoses included, but were not limited to, end stage renal disease and hypotension. The dialysis care plan indicated he required hemodialysis on Monday, Wednesday and Friday. He left the facility at 6:00 a.m. and returned around 11:30 a.m. The goal was for him to be free from complications related to dialysis. An intervention was to administer medications, as ordered. The impaired cardiac output care plan, revised 2/21/24, indicated the goal was for him to be free from complications and symptoms of cardiac dysfunction. An intervention was to observe for signs/symptoms of cardiac dysfunction such as decreased heart rate or blood pressure, initiated	F 0684	1 F684 **Actions taken for resident affected.** Immediate action(s) taken for residents #52, # 64, #45 and # 14 were found to have been affected by the alleged deficiency include: **Residents #52, #64, # 45 and #14 were assess by the Director of Nursing Services for immediate concerns. None identified at this time.** 2. **Identification of other residents having the potential be affected was accomplished by** All residents who have an order for compression hose, daily weights and use of vasopressors have the potential to be affected. 100% audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident that have orders for compression hose, daily weights and on a Vasopressor for following MD orders on 8/8/24. No further concerns were identified.	08/12/2024

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	155491	A. BUILDING 00 B. WING	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	3/20/22. The physician's orders indicated he had dialysis appointments three times a week on Monday, Wednesday, and Friday. The physician's orders indicated to administer a 10 mg (milligrams) tablet of Midodrine one time a day every Monday, Wednesday, and Friday for low blood pressure one hour prior to dialysis, starting 10/18/23. There was no parameter on the blood pressure indicating what constituted a low blood pressure. There was another order to administer a 10 mg tablet of Midodrine every 12 hours as needed for a systolic blood pressure equal to or less than 100 on non-dialysis days, starting 3/28/24. There was no order for blood pressure to be taken on non-dialysis days. The July 2024 MAR (medication administration record) indicated the regularly scheduled Midodrine was not administered on Wednesday, 7/3/24, or Monday, 7/15/24. It indicated the as needed Midodrine was not administered at all in the month July 2024 thus far, but there were no regularly documented blood pressure results for non-dialysis days in the clinical record verifying Resident 52's systolic blood pressure was not equal to or less than 100 and didn't require administration. The 6/26/24 nurse practitioner note indicated Resident 52 verbalized that blood pressure had been low at dialysis and "discussion with nursing - HD [hemodialysis] reports SBP [systolic blood pressure] dropping less than 80 during treatment." The Assessment and Plan section of the note indicated to add Midodrine 10 mg the night before dialysis in addition to the prn (as needed) morning dose. The Midodrine orders in this note did not match Resident 52's above physician's orders or		3. **Actions taken/systems put in place to reduce the risk of future occurrence** **Include:** QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. On 8/6/2024, education was initiated and will continue until all RN/LPN /care team members have been educated on ensuring that Physicians orders are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, Unit Managers. Education completed on 8/12/24. 4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit daily weight, compression hose application, and following Physician orders 3 x weekly x 3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI	

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	July 2024 MAR. An interview was conducted with the DON (Director of Nursing) on 7/26/24 at 12:10 p.m. She reviewed Resident 52's Midodrine orders and indicated she was not sure what his Midodrine orders were supposed to be; why the Midodrine was not administered on 7/3/24 or 7/15/24; or why blood pressures were not being obtained on non-dialysis days, but she would get clarification. 2. The clinical record for Resident 64 was reviewed on 7/29/24 at 10:48 a.m. The diagnoses included, but were not limited to, congestive heart failure and edema. The at risk for fluid imbalance care plan, revised 7/26/24, indicated the goal was to remain free of signs of fluid overload. Interventions were to administer medications as ordered, initiated 10/24/23, and weights as ordered/indicated and to notify physician of significant weight changes, initiated 10/24/23. The physician's orders indicated to obtain daily weight and notify the physician of a weight gain greater than 3 pounds in a day or 5 pounds in a week, starting 10/25/23. They indicated to administer a 2.5 mg tablet of Metolazone one time a day for a diuretic, starting 6/12/24. The July 2024 MAR indicated a 4.7 pound gain on 7/5/24 from the previous day, a 5.8 pound gain on 7/7/24 from the previous day, and a 7.8 pound gain on 7/25/24 from the previous day. There was no information in the clinical record to indicate the physician was informed of these over 3 pounds in a day weight gain. There were no weights recorded on 7/13/24, 7/19/24, and 7/27/24 in the July 2024 MAR.		Committee until such a time consistent substantial compliance has been achieved as determined by committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI will be held on 8/22/24.Audited records will be reviewed by the Risk Management/ Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee 5. Corrective action complete date:08/12/24	

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The 7/26/24 progress note indicated, "Cardiology called today with lab results for Pro BNP [Brain natriuretic peptide-blood test that detects heart failure]. Pro BNP was elevated, cardiologist wants to increase Metolazone Tablet from 2.5 mg to 5 mg. Get daily weight, call cardiologist if 3 lb weight gain."

The current physician's orders indicated the Metolazone was not increased from 2.5 mg to 5 mg, as indicated, in the above verbal order. The July 2024 MAR indicated Resident 64 continued to receive 2.5 mg of Metolazone 7/27/24, 7/28/24, and 7/29/24, after the verbal order to increase to 5 mg.

An interview was conducted with the DON on 7/29/24 at 1:00 p.m. She indicated there was no verification the physician was notified of Resident 64's daily weight gain more than 3 pounds on 7/5/24, 7/7/24, or 7/25/24, and she was going to proceed with changing the Metolazone order.
3. The clinical record for Resident 45 was reviewed on 7/24/24 at 2:17 p.m. The diagnoses included, but were not limited to, dependance on respirator (ventilator) status, chronic pain syndrome, depression, morbid (severe) obesity, generalized anxiety disorder, and unspecified cirrhosis of liver.

The Quarterly Minimum Data Set (MDS) assessment for Resident 45, dated 4/18/24, indicated the resident was cognitively intact for daily decision making.

During an interview with Resident 45, on 7/23/24 at 1:30 p.m., indicated he had a gastrointestinal tube (G-tube) that he had been waiting to be removed. Resident 45 indicated that the g-tube had never been used and it occasionally would

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	bleed. During an interview and observation with Resident 45, on 7/24/25 at 10:38 a.m., indicated that the g-tube would be painful if he laid on it wrong. No redness or drainage was observed from the g-tube site. The physician order for Resident 45, dated 6/28/24 at 12:39 p.m., indicated the resident's g-tube was to be removed. A physician's order and resident face sheet was faxed to the hospital central scheduling office. During an interview with the Corporate Director of Respiratory, on 7/25/24 at 12:27 p.m., they indicated the g-tube removal order was initially placed, on 6/28/24, but did not include the resident's diagnosis. So, the order had to be re-written on 7/2/24. On 7/8/24, the order was faxed again to the hospital central scheduling office clarifying Resident 45's diagnosis, date of birth, and the physician's printed name. During an interview with the Corporate Director of Respiratory, on 7/25/24 12:07 p.m., they indicated the facility called central scheduling to schedule an appointment with a gastro-intestinal doctor [GI doctor] to remove the g-tube, and faxed them all the information, then they get back with us to make the appointment, and the facility was still waiting to hear back from the hospital. The Corporate Director of Respiratory indicated the nurses were responsible to follow up on Resident 45's g-tube removal. An interview conducted with the Regional Nurse Consultant 2, on 7/26/24 at 2:10 p.m., indicated			

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	that the facility did not have a policy for following physician's orders. The facility followed the standards of practice. An "Appropriate Use of Feeding Tubes policy" provided by the Reginal Nurse Consultant 2, on 7/26/24 at 2:10 p.m., indicated the following,"...Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary". 4. The clinical record for Resident 14 was reviewed on 7/24/2024 at 1:20 p.m. The medical diagnosis included chronic obstructive pulmonary disease. The Quarterly Minimum Data Set Assessment, dated 6/14/2024, indicated that Resident 14 was cognitively intact and needed assistance of setup to limited for dressing. A care plan, revised on 2/21/2024, indicated that Resident 14 had impaired cardiac function. An intervention, dated 5/12/2022, indicated for Resident to utilize compression socks as ordered. A physician order, dated 3/16/2020, indicated for Resident 14 to have compression stockings placed in the morning and off in the evening for edema. An interview and observation, on 7/23/2024 at 12:36 p.m., indicated that Resident 14 was sitting in his recliner with his feet elevated. White tube socks were wrinkled at the ankle and indented the skin. Resident 14 indicated that he had edema for a while, and they have not been placing his compression stockings or ace wraps. He stated the swelling is "uncomfortable" and that he cannot get his compression stockings on or place			

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	them on his own. An interview and observation, on 7/25/2024 at 11:05 a.m., indicated that Resident 14 was sitting in his recliner with his feet elevated. White tube socks were wrinkled at the ankle and indented the skin. Resident 14 indicated that he had edema that was unchanged, and they have not placed his compression stockings all week. An interview and observation with Licensed Practical Nurse 3, on 7/25/2024 at 11:10 a.m., indicated that she did mark off the treatment record that Resident 14's compression stockings were administered, but she had not placed them yet. She completed an assessment of Resident 14's swelling of plus one pitting edema. She indicated this was baseline for Resident 14 and that compression stockings should have been in place. An interview with Regional Nurse Consultant 1, on 7/26/2024 at 2:10 p.m., indicated there was not a specific policy for following physician orders. The facility would follow the standards of practice to follow physician orders as written unless clinically contraindicated. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident's urinary catheter drainage bag and/or tubing remained free of contact with the floor for 1 of 2 residents reviewed for indwelling urinary catheters. (Resident 33) Findings include: The clinical record for Resident 33 was reviewed on 7/26/2024 at 11:35 a.m. The medical diagnoses included obstructive uropathy, urinary tract	F 0690	1 F690 **Actions taken for resident affected.** Immediate action(s) taken for resident # 33 that was found to have been affected include: **Resident #33 was assessed by the Director of Nursing Services for immediate concerns. None identified at this time.** 2. **Identification of other residents having the potential**	08/12/2024

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	infections, and dysuria. A Quarterly Minimum Data Set Assessment, dated 5/3/2024, indicated that Resident 33 was mildly cognitively impaired, had an indwelling urinary catheter, and needed extensive assistance of staff for toileting needs. A urinary catheter care plan, revised on 2/23/2023, indicated that Resident 33 was at risk for complications and infection related to utilizing an indwelling catheter for treatment of obstructive uropathy. A physician order, dated 6/11/2024, indicated that Resident 33 utilized an indwelling catheter for obstructive uropathy. An observation of Resident 33, on 7/23/2024 at 2:10 p.m., indicated he was sitting in his wheelchair by the nurses' station. This urinary catheter tubing was contacting the floor. An observation of Resident 33, on 7/26/2024 at 11:09 a.m. indicated that the urinary catheter drainage bag was hanging off the side of the bed and contacting the floor. An observation and interview of Resident 33, on 7/26/2024 at 11:16 a.m., indicated that his urinary catheter bag was hanging off the side of his bed. Certified Nursing Assistant (CNA) 4 verified that the bag was contacting the floor. She did not know how she should ensure the catheter was not contacting the floor. An interview with the Regional Nurse Consultant 1, on 7/26/2024 at 2:25 p.m., indicated that is the current standard of practice for the urinary catheter tubing and drainage bag to remain free of		**be affected was accomplished by** All residents who have an order for Foley Catheters have the potential to be affected. 100% audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident that have orders for Foley Catheters on 8/8/24. No further concerns were identified. 3. **Actions taken/systems put in place to reduce the risk of future occurrence Include:** QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, and two , and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. On 8/6/2024, education was initiated and will continue until all RN/LPN /care team members have been educated on ensuring that Physicians orders are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, Unit Managers.	

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	contact with the floor. A policy entitled, "Appropriate Use of Indwelling Catheters", was provided by the Regional Nurse Consultant 1 on 7/26/2024 at 2:25 p.m. The policy indicated the following, " ...Indwelling urinary catheter (urethral or suprapubic) will be utilized in accordance with current standards of practice ..." 3.1-41(a)(2)		Education completed on 8/12/24. 4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit for Foley catheter tubing/bag touching the floor. 3 x weekly x 3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time consistent substantial compliance has been achieved as determined by committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI will be held on 8/22/24. Audited records will be reviewed by the Risk Management/ Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee. 5. Corrective action complete date:08/12/24	

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F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to routinely assess a resident receiving pain medications and administer narcotic pain medication for a resident with chronic pain for 1 of 1 resident reviewed for pain. (Resident 12) Findings include: The clinical record for Resident 12 was reviewed on 7/25/2024 at 1:15 p.m. The medical diagnosis included chronic pain syndrome. A Quarterly Minimum Data Set Assessment, dated 5/20/2024, indicated that Resident 12 was cognitively intact, received routine and as needed pain medication, and was almost constantly in pain. A pain care plan, revised on 3/8/2024, indicated Resident 12 was at risk for pain related to her chronic pain syndrome. A care planned intervention of administering medications as ordered was dated 5/3/2021. A physician order, dated 7/11/2024, indicated for Resident 12 to receive tramadol 50 milligrams (mg) three times a day routinely for pain. A physician order, dated 5/18/2023, indicated for	F 0697	1 F697 **Actions taken for resident affected.** Immediate action(s) taken for resident #12 that was found to have been affected include: **Resident #12 was assessed by the Director of Nursing Services for immediate concerns. None identified at this time.** 2. **Identification of other residents having the potential be affected was accomplished by** All residents who have an order for narcotic medication have the potential to be affected. 100% audit of all residents who have ordered narcotics were completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident that have orders for narcotic have the medication available for administering and monitored for pain on 8/8/24. No further concerns were identified.	08/12/2024

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	Resident 12 to receive Tylenol 650 mg by mouth every six hours routinely for pain. During an interview, on 7/23/2024 at 12:55 p.m., Resident 12 indicated that last week she went without her pain medication for two days. During that time, her pain was elevated, but it did not keep her from doing her usual routine. Family Member was present during the interview. He indicated Resident 12 appeared uncomfortable those two days when he was visiting and that the staff told him the facility could not get the pain medication because of the "outage". Review of the July 2024 medication administration record for Resident 12 indicated that she did receive her routine Tylenol as ordered, but not receive her routine tramadol for four doses as follows: 7/18/2024 - 6:00 p.m., 7/19/2024 - 7:00 a.m., 7/19/2024 - 3:00 p.m., & 7/19/2024 - 6:00 p.m. A rounding document, dated 7/19/2024, indicated that "pain was managed with tramadol." No pain scale or assessment were documented between, 7/18/2024 at 5:36 p.m., and 7/20/2024 at 6:11 a.m. A policy, entitled "Pain Management", was provided by the Regional Nurse Consultant on 7/26/2024 at 2:10 p.m. The policy indicated the following, " ...Residents receiving routine pain medications should be assessed each shift by the charge nursing during round and/or medication pass ..."		3. **Actions taken/systems put in place to reduce the risk of future occurrence** **Include:** QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. On 8/6/2024, education was initiated and will continue until all RN/LPN /care team members have been educated on ensuring that Physicians orders are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, Unit Managers. Education completed on 8/12/24. 4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit for need for ordering of Narcotics to ensure that medication is available. 3 x weekly x 3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI	

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	3.1-37(a)		Committee until such a time consistent substantial compliance has been achieved as determined by committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI will be held on 8/22/24. Audited records will be reviewed by the Risk Management/ Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee. 5. Corrective action complete date:08/12/24	
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this			

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	subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on observation, interview, and record review, the facility failed to timely follow-up on scheduling a resident's appointment for a CT (computerized tomography-diagnostic imaging procedure that uses x-rays and computers to create detailed images of the inside of the body) scan for 1 of 2 residents reviewed for skin conditions. (Resident 52) Findings include: The clinical record for Resident 52 was reviewed on 7/26/24 at 2:15 p.m. His diagnoses included, but were not limited to, osteoarthritis and end stage renal disease. An observation and interview was conducted with Resident 52 on 7/25/24 at 2:29 p.m. He was lying in bed in his room. He indicated he knew he was supposed to have a CT scan of his back, but the facility never followed up with him on when the appointment would be. The physician's orders indicated a referral for a CT scan of the spine without contrast including cervical, lumbar, and thoracic spine with a local hospital provider, effective 7/10/24. The 7/10/24 order note indicated the following, "New order received by NP (nurse practitioner) for a CT scan of the spine with no contrast. Including the cervical, thoracic, and lumbar spine. Referral was sent to [name of local provider] central	F 0776	1 F776 **Actions taken for resident affected.** Immediate action(s) taken for resident #52 that was found to have been affected include: **Resident #52 was assessed by the Director of Nursing Services for immediate concerns. None identified at this time.** 2. **Identification of other residents having the potential be affected was accomplished by** All residents who have an order or need for appointment for outside facility Radiology/ Diagnostic Services have the potential to be affected. 100% audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident that have an order for an appointment are followed until appointment has been made with outside agencies. No further concerns were identified. 3. **Actions taken/systems**	08/12/2024

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	scheduling." The note included a fax and phone number for the provider. There was no information in the clinical record to indicate a CT scan appointment was scheduled or follow-up with the local provider after the referral was sent on 7/10/24. An interview was conducted with the DON (Director of Nursing) on 7/26/24 at 11:06 a.m. She indicated the process for scheduling CT scans was to call the local provider to let them know they needed an appointment and send the order to the provider. The provider would call back with an appointment or to let them know if they needed any additional information. She knew staff called to schedule the appointment, but there was no verification of any follow-up before now. She spoke with central scheduling at the local provider to which Resident 52's CT scan referral was sent. They needed a diagnosis code, so they were going to get that today, on 7/26/24, and get the appointment scheduled. 3.1-49(g)		**put in place to reduce the risk of future occurrence Include:** QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. On 8/6/2024, education was initiated and will continue until all RN/LPN /care team members have been educated on ensuring that Physicians orders are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, Unit Managers. Education completed on 8/12/24. 4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will audit for need for scheduling of outside of facility for Radiology/Diagnostic Services. 3 x weekly x 3 months then monthly for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time consistent substantial compliance has been achieved as	

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			determined by committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI will be held on 8/22/24. Audited records will be reviewed by the Risk Management/ Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee 5. Corrective action complete date:08/12/24	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;			

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	§483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, interview and record review, the facility failed to ensure a resident was seen for routine dental services for 1 of 4 residents reviewed for dental services. (Resident 1) Findings include: During an observation and interview with	F 0791	F791 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident 1 was added to the list to be seen by dentist on 8/20/24. **How other residents having the**	08/12/2024

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	Resident 1, on 7/25/24 at 11:00 a.m., she indicated it was difficult for her to eat because she did not have any teeth. The resident indicated she would like to have dentures. The resident was observed to have no lower or upper teeth. Review of the record of Resident 1, on 7/25/24 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinsonism, chronic obstructive pulmonary disease, dementia, diabetes, atherosclerotic heart disease, major depressive disorder, paranoid personality disorder, and conversion disorder with seizures. . The Annual Minimum Data Set assessment for Resident 1, dated 4/4/24, indicated the resident was cognitively intact for daily decision making. The resident was edentulous (no natural teeth). During an interview with Social Services 1, on 7/26/24 at 11:04 a.m., indicated Resident 1 had not seen a dentist since June 2023. The dentist made impressions for the resident to get dentures at that time. The dentures were not made because the dentist did not hear from the Power of Attorney (POA). Social Services would be responsible for following up with the POA and dentist. The resident now has an appointment for next month. The Dental policy provided by the Director of Nursing, on 7/29/24 at 1:15 p.m., indicated the facility would obtain routine dental services. 3.1-24(a)(1)		**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. An entire house audit was conducted by the Social Service Director and Memory Care Facilitator by 8/8/24 to ensure that all residents had routine dental services according to their preferences and were added to be seen by dentist if needed. **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur.** Administrator/Dept Heads provided education by 8/12/24 for staff notifying social services when there is a dental need. In addition, social services will speak with all residents or family members in their quarterly care plan meetings to update any dental preferences they may have. QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place. Administrator/Social Services will audit 3 residents weekly for 12 weeks to ensure they have routine dental services per their preferences. Results of these audits will be brought to QAA and reviewed by the Administrator. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI meeting will be held on 8/22/24. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared by the Risk Management/Quality Assurance Committee.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or			

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	(ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to document treatments were completed, or refused, and failed to document if enteral feeding were administered, or refused, for 1 of 23 residents reviewed for documentation (Resident C). Finding include: Review of the record of Resident C, on 7/26/24 at 2:14 p.m., indicated the diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, quadriplegia, dependence on respirator (ventilator) status, neuromuscular dysfunction, tracheotomy and gastrostomy (g-tube) status. During an interview with the Corporate Director of Respiratory, on 7/29/24 at 2:42 p.m., he verified the following treatments were not documented as completed, or refused on the May 2024 Treatment Administration Record (TAR) and verified that the	F 0842	1 F 842 **Actions taken for resident affected.** Immediate action(s) taken for resident # c that was found to have been affected include: **Resident #C has been discharged from facility.** 2. **Identification of other residents having the potential be affected was accomplished by** All residents who refuse treatments have the potential to be affected. Audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/or designee, to ensure that each resident that have noted to have refusal of	08/12/2024

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	enteral g-tube feeding was not documented as provided or refused. The May 2024 TAR for Resident C indicated Dakins (1/2 strength) external solution to left buttock every shift. Apply wound cleanser, Dakins moistened fluffed gauze, and cover with an ABD (abdominal) pad. There was no documentation the treatment was completed, or refused, for 5/19/24 for day shift and nightshift; 5/20/24, 5/21/24, 5/31/24 for day shift; and 5/28/24 for nightshift. The May 2024 TAR for Resident C indicated Dakins (1/2 strength) external solution to the right buttock every shift. Apply wound cleanser, Dakins moistened fluffed gauze, and cover with an ABD pad. There was no documentation the treatment was completed, or refused, for 5/19/24 for day shift and nightshift; 5/20/24, 5/21/24 and 5/31/24 for day shift; and 5/28/24 for nightshift. The May 2024 TAR for Resident C indicated to cleanse right lateral foot with wound cleanser, apply betadine, and leave open to air two times a day for wound care. There was no documentation the treatment was completed, or refused, for 5/4/24, 5/7/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24 and 5/18/24 for day shift; and 5/8/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24 for evening shift. The May 2024 TAR for Resident C indicated to cleanse with wound cleanser, apply calcium alginate, and cover with a border dressing two times a day to the right lateral leg. There was no documentation the treatment was completed, or refused, for 5/7/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24, 5/18/24 for day shift; and 5/8/24, 5/12/24, 5/13/24, 5/14/23, 5/15/24 for evening shift.		treatments have been documented on 8/8/24. No further concerns were identified. 3. **Actions taken/systems put in place to reduce the risk of future occurrence Include:** QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, two, and three, and Social Services, Memory Care Coordinator to review the plan and findings. This action was completed by the Executive Director on 7/30/24. On 8/6/2024, education was initiated and will continue until all RN/LPN /care team members have been educated on ensuring that Physicians orders are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, Unit Managers. Education completed on 8/12/24. 4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit for refusal documentation. 3 x weekly	

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MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	The May 2024 TAR for Resident C indicated to cleanse with wound cleanser, apply collagen to wound, and cover with ABD pad to the right elbow. There was no documentation the treatment was completed, or refused, for 5/4/24, 5/7/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24, 5/18/24 for day shift; and 5/8/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24 for evening shift. The May 2024 TAR for Resident C indicated to cleanse the coccyx wound with wound cleanser, apply alginate, and cover two times a day. There was no documentation the treatment was completed, or refused, for 5/4/24, 5/7/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24, 5/18/24 for day shift; and 5/8/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24 for evening shift. The May 2024 TAR for Resident C indicated to cleanse the left and right buttock and right ischium with wound cleanser, apply alginate, and cover. There was no documentation the treatment was completed, or refused, for 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24 for day shift; and 5/8/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24 for evening shift. The May 2024 TAR enteral feed order indicated Resident C was to have g-tube feeding formula at 55 milliliters (ml) every hour for 12 hours. There was no documentation the resident received the formula, or refused, the feeding formula for 5/9/24, 5/11/24, 5/19/24. The documentation policy provided by the Assistant Vice President of Clinical Services, on 7/29/24 at 2:10 p.m., indicated each resident record shall contain an accurate representation of the actual experiences of the resident to include accurate and timely documentation.		x 3 months then monthly for 2 months, then Quarterly thereafter. Audits will be reviewed by the QAPI Committee until such a time consistent substantial compliance has been achieved as determined by committee. Audit results will be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, and Unit Managers review audits, education, results, and findings. The next QAPI will be held on 8/22/24. Audited records will be reviewed by the Risk Management/ Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee 5. Corrective action complete date:08/12/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	3.1-50(a)(1) 3.1-50(a)(2)			