| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
|--|--|---|---|--|--|
| | | 1029 E | 5TH STREET | | |
| (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | | |
| Licensure Survey. Investigation of Con IN00436425 and IN Complaint IN00436 the allegations are complaint IN0 | This visit included the implaints IN00436424, 100436426 6424 - No deficiencies related to sited. 6425 - No deficiencies related to sited. 6426 - No deficiencies related to sited. 23, 24, 25, 26, & 29, 2024. 0316 655491 86370 | F 0000 | Please accept the following Pl of Correction as our credible submission of compliance. We respectfully request a desk rein lieu of a post survey revisit. | e view | |
| Quality review com | pleted on August 2, 2024. | | | | |
| | This visit was for a Licensure Survey. Investigation of Complaint IN00436 the allegations are complaint IN00 | IDENTIFICATION NUMBER 155491 PROVIDER OR SUPPLIER IC CARE OF CONNERSVILLE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 | TOF DEFICIENCIES OF CORRECTION 155491 | TO DEFICIENCIES OF CORRECTION DENTIFICATION NUMBER 155491 ROVIDER OR SUPPLIER C CARE OF CONNERSVILLE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00436424, IN00436425 and IN00436426 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 AlM number: 100286370 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 2 Medicare: 2 Medicare: 2 Medicare: 2 Medicare: 2 Medicare: 3 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Matt Elwell HFA 08/09/2024

Any defiency statement 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 disclodays 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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) E | | (X3) DATE |) DATE SURVEY | |
|---|---|----------------------------------|-----------------------------------|--------|---|---------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | ETED |
| | | 155491 | B. WING 07/29/2024 | | | /2024 | |
| | | | | CTREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | 5TH STREET | | |
| MA IESTI | C CARE OF CONN | IEDSVII I E | | | ERSVILLE, IN 47331 | | |
| IVIAJESTI | C CARL OF CON | ILIOVILLE | | CONNE | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| F 0558 | 483.10(e)(3) | | | | | | |
| SS=D | Reasonable Accor | mmodations | | | | | |
| Bldg. 00 | Needs/Preference | | | | | | |
| | - ' ' ' ' | right to reside and receive | | | | | |
| | | ility with reasonable | | | | | |
| | | f resident needs and | | | | | |
| | | ot when to do so would | | | | | |
| | _ | th 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 | | F 03 | 558 | 1 F558 Actions taken for | ' | 08/12/2024 |
| | | | | | resident affected. | | |
| | | | | | Immediate action(s) tal | ken | |
| | | | | | for resident #54, 18, and 1 | | |
| | reviewed for hydration (Resident 54, Resident 18 | | | | Resident # 54 & | | |
| | and Resident 1). | | | | #18 was assessed by Directo | | |
| | | | | | Nursing Services for hydratic | | |
| | Findings include: | | | | needs. None identified duri | ng | |
| | | | | | this time. Resident #1 is | | |
| | - | ation, on 7/24/24 at 11:36 a.m., | | | deceased | | |
| | - | ng in bed, the resident had a | | | | | |
| | | n the bedside table, the table | | | | | |
| | | out of reach of the resident, | | | 2. Identification of other | | |
| | | not have any water in his | | | residents having the potentia | al | |
| | room. | | | | to be affected was | | |
| | | | | | accomplished by: | | |
| | _ | on, on 7/25/24 at 10:54 a.m., | | | | | |
| | • | ng in bed, the resident had no | | | All residents residing on the | | |
| | water or any type of | f fluids in his room. | | | Advance Dementia Unit have | | |
| | | T/05/04 + 10 50 | | | potential to be affected. 100% | י | |
| | _ | on, on 7/25/24 at 12:53 p.m., | | | audit of all residents was | | |
| | • | ng in bed, the resident had no | | | completed by the Nursing | | |
| | water or any type of | f fluids in his room. | | | Management Team including | , | |
| | D 1 4 | 7/26/24 4 11 47 | | | Assistant Director of Nursing, | | |
| | _ | on, on 7/26/24 at 11:47 a.m., | | | Managers and/or designee, to | | |
| | - | ng in bed, the resident had a | | | ensure that each resident had | | |
| | | ice water in it on the bedside | | | hydration available in room an | .u | |
| | resident's reach. | across the room and out of the | | | within reach. | | |
| | resident's reach. | | | | No further concerns were | | |
| | Daviary of 41. | d of Davidant 54 c = 7/20/24 -4 | | | No further concerns were | | |
| | keview of the recor | d of Resident 54, on 7/29/24 at | | | identified. | | |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURV | VEY |
|-----------|---|---|--------|------------|---|----------------|----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETEI | D |
| | | 155491 | B. W | ING | | 07/29/202 | 4 |
| | | | | CTREET | A DDDEGG CITY CTATE ZID COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| NAA 1505 | 10 04 DE 05 00NIN | IEDOV (II. I. E | | | 5TH STREET | | |
| MAJEST | IC CARE OF CONN | NERSVILLE | | CONNE | ERSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DROWINED BY AN OF CORDECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | . co | MPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | - | DATE |
| | 11:28 a.m., indicate | ed the diagnoses included, but | | | | | |
| | were not limited to, Alzheimer's disease, dementia, | | | | 3. Actions taken/syste | ms | |
| | seizure disorder, an | | | | put in place to reduce the ris | | |
| | hypokalemia. | | | | of future occurrence | .` | |
| | пуроканенна. | | | | Include: | | |
| | The July 2024 physician recapitulation for | | | | | | |
| | | ed the resident was ordered | | | QAPI meeting was held with the | ne l | |
| | thin liquids. | | | | Executive Director, Director of | | |
| | timi nquius. | | | | Nursing, Assistant Director of | | |
| | The plan of care for Resident 54, dated 3/15/22, | | | | Nursing, Assistant Director of Nursing, Unit Manager one an | ۱ ا | |
| | _ | | | | two also present Social Service | | |
| | indicated the resident had a history of urinary tract infections. The interventions included, but | | | | for Memory Care units and So | | |
| | were not limited to, encourage fluids. | | | | services #2 to review the plan | | |
| | were not limited to, encourage fluids. | | | | - | ' | |
| | 2. During an observation, on 7/23/24 at 12:40 p.m., | | | | and findings. This action was | | |
| | _ | have any fluids available in | | | completed by the Executive | | |
| | his room. | have any fluids available in | | | Director on 7/30/20244. On | | |
| | nis room. | | | | 8/5/24, education was initiated | | |
| | D | | | | and will continue until all | _ | |
| | _ | ion, on 7/24/24 at 11:40 a.m., have any fluids available in | | | RN/LPN/Nursing & Activity car | е | |
| | his room. | have any nuius avanable in | | | team members have been | | |
| | ilis fooili. | | | | educated on ensuring that | | |
| | During on observati | ion, on 7/25/24 at 10:52 a.m., | | | residents are offered fluids | | |
| | _ | | | | throughout the day on the | | |
| | his room. | have any fluids available in | | | Advanced Dementia Unit and | are | |
| | nis room. | | | | within reach. Nursing | h a | |
| | During on absor | ion, on 7/26/24 at 11:44 a.m., | | | Management Team including | ile | |
| | _ | | | | Director of Nursing, Assistant | | |
| | | Styrofoam cup of ice water in | | | Director of Nursing, Weekend | | |
| | his room. | | | | Supervisor, Unit Managers. | | |
| | Daviery of the | d of Docident 19 7/20/24 -4 | | | Completed on 08/12/2024 | | |
| | | rd of Resident 18, on 7/29/24 at | | | | | |
| | | ed the resident's diagnoses | | | 4. How the corrective | | |
| | | not limited to, schizophrenia, | | | action(s) will be monitored to | ' | |
| | | r depressive disorder, | | | ensure the practice will not | | |
| | | e, dementia and moderate | | | reoccur: | | |
| | intellectual disabilit | ties. | | | | | |
| | | | | | The Director of Nursing, Assis | ant | |
| | | ician recapitulation for | | | Director of Nursing, and Unit | | |
| | _ | ed the resident was ordered | | | Managers will randon | • | |
| | thin liquids. | | | | audit documentation for offerir | g | |

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AFQM11 Facility ID: 000316

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | IULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|-----------------------------------|--------|-------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 00 | COMPL | ETED |
| | | 155491 | B. W | ING | | 07/29/ | 2024 |
| | | | | CTREET | ADDRESS SITY STATE ZID COD | | |
| NAME OF F | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| NAA JEGT | 10 04 DE 05 00 N | IEDOV (II. I. E | | | 5TH STREET | | |
| MAJEST | IC CARE OF CONN | NERSVILLE | | CONNE | ERSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | fluids through the day & ensur | e | |
| | 3. During an observ | vation, on 7/25/24 at 11:00 a.m., | | | that hydration is within reach. | | |
| | _ | g in bed and the resident had | | | audit will be conducted weekly | | |
| | no fluids available in her room. During an observation, on 7/26/24 at 11:49 a.m., | | | | months then monthly for 2 | , , , | |
| | | | | | months, then Quarterly. Audi | te | |
| | | | | | will be reviewed by the QAPI | | |
| | 1 | g in bed and had no fluids | | | Committee until such a time | | |
| | | m. The resident indicated she | | | consistent substantial complia | nce | |
| | | received one cup of ice water a | | | has been achieved as determine | | |
| | day. | control one cup of fee water a | | | by committee. Audit results w | | |
| | auy. | | | | be shared with QAPI. QAPI | 111 | |
| | Review of the recor | d of Resident 1, on 7/25/24 at | | | meeting 07/30/24 was held wi | th | |
| | | ed the resident's diagnoses | | | the Executive Director, MDS, | uı | |
| | | not limited to, Parkinson's | | | Social Services, Memory Care | | |
| | | structive pulmonary disease, | | | | ; | |
| | | atherosclerotic heart disease, | | | Unit Coordinator, Director of | | |
| | | | | | Nursing, Assistant Director of | | |
| | | sorder, paranoid personality | | | Nursing, and Unit Managers re | | |
| | disorder, and conve | rsion disorder with seizures. | | | audits, education, results, and | | |
| | The Assessed Mississes | D-4- C-4 4 f- :: | | | findings. The next QAPI will be | | |
| | | um Data Set assessment for | | | held on 8/22/24. Audited reco | oras | |
| | | 4/24, indicated the resident | | | will be reviewed by the Risk | | |
| | was cognitively inta | act for daily decision making. | | | Management/ Quality Assurar | ice | |
| | | | | | Committee until such time | | |
| | | ion policy provided by the | | | consistent substantial complia | | |
| | | , on 7/29/24 at 1:15 p.m., | | | has been achieved as determ | | |
| | l . | y would strive to provide | | | by the committee. Audit resul | ts | |
| | _ | e Nurse aides would provide | | | will be shared with the Risk | | |
| | _ | edside fluids on a routine | | | Management/Quality Assuran | ce | |
| | basis as part of dail | y care. | | | Committee | | |
| | | | | | | | |
| | 3.1-3(v)(1) | | | | 5. Corrective action | | |
| | | | | | complete date: 08/12/24 | | |
| | | | | | | | |
| F 0584 | 483.10(i)(1)-(7) | | | | | | |
| SS=E | Safe/Clean/Comfo | ortable/Homelike | | | | | |
| Bldg. 00 | Environment | | | | | | |
| | §483.10(i) Safe Ei | | | | | | |
| | | a right to a safe, clean, | | | | | |
| | comfortable and h | omelike environment, | | | | | |
| | including but not li | imited to receiving | | | | | |

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PRINTED: 08/14/2024 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | OM | IB NO. 0938-039 |
|--|---|---|-------|--|---|---|----------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491 | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
| | PROVIDER OR SUPPLIEF | | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | Ε | (X5) COMPLETION DATE |
| | The facility must p §483.10(i)(1) A sa homelike environr to use his or her p extent possible. (i) This includes e can receive care at the physical layou resident independs afety risk. (ii) The facility sha for the protection from loss or theft. §483.10(i)(2) Houservices necessal orderly, and comform services necessal orderly, and comform in good condition (iv); §483.10(i)(4) Privatesident room, as (iv); §483.10(i)(5) Adelighting levels in a service in good condition (iv); | Ife, clean, comfortable, and ment, allowing the resident personal belongings to the insuring that the resident and services safely and that it of the facility maximizes bence and does not pose a sell exercise reasonable care of the resident's property is sekeeping and maintenance by to maintain a sanitary, portable interior; and bed and bath linens that tion; attended to the specified in §483.90 (e)(2) in quate and comfortable and safe is. Facilities initially certified the maintenance of the maintenance of the maintenance of | | | | | |
| | Based on observation | on, interview, and record | F 0: | 584 | F584 What corrective action will | be | 08/12/2024 |

review, the facility failed to provide a homelike

accomplished for those

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|--|--|--------|------------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED |
| | | 155491 | B. W | ING | | 07/29/2024 |
| | | <u> </u> | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | 5TH STREET | |
| MAJEST | IC CARE OF CON | NERSVII I E | | | ERSVILLE, IN 47331 | |
| | 1 | 121101122 | | | 1 | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | , | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | | 5.112 |
| | | of 7 residents reviewed for | | | residents found to have been | n |
| | , | lent 18, Resident 1, Resident | | | affected by the deficient | |
| | 75, Resident 38, and | d Resident 64). | | | practice. | _ |
| | Findings include: | | | | Residents 1,18, 38, 64, and 7 | 5 |
| | | | | | rooms were all evaluated for | |
| | 1.5. | 7/22/24 . 12 40 | | | alleged deficiencies related to | 1 |
| | _ | vation, on 7/23/24 at 12:40 p.m., som was bare. The resident had | | | citation F584 and corrected | |
| | | | | | accordingly. | 41 |
| | | ings and no pictures. The en clock on the wall. | | | How other residents having | |
| | resident had a broke | en clock on the wall. | | | potential to be affected by the | I |
| | During on observat | ion on 7/25/24 at 10:52 a m | | | same deficient practice will l | |
| | During an observation, on 7/25/24 at 10:52 a.m., Resident 18's bedroom was bare. The resident had | | | | identified and what corrective | e |
| | no personal belongings and no pictures. The | | | | action(s) will be taken. | al to |
| | | en clock on the wall. | | | All residents have the potential be affected. | al 10 |
| | lesident nad a broke | en clock on the wan. | | | Administrator/Maintenance | |
| | Review of the recor | rd of Resident 18, on 7/29/24 at | | | Director audited all facility roo | me |
| | | ed the diagnoses included, but | | | to identify any further deficien | |
| | | schizophrenia, hypertension, | | | including anything in disrepair | |
| | | sorder, Alzheimer's disease, | | | not being homelike and correct | |
| | | erate intellectual disabilities. | | | them if needed. | neu |
| | | | | | What measures will be put in | nto |
| | The plan of care for | r Resident 18, dated 8/3/22, | | | place and what systematic | |
| | _ | nt desired to remain in the | | | changes will be made to | |
| | | The interventions included, but | | | ensure that the deficient | |
| | | encourage resident and family | | | practice does not recur. | |
| | | and homelike environment. | | | Administrator/Dept Heads | |
| | | | | | educated all facility staff by | |
| | The plan of care for | r Resident 18, dated 8/4/22, | | | 8/12/2024 on identifying and | |
| | _ | nt resided on a secured | | | reporting any potential deficie | ncies |
| | memory care unit d | ue to diagnosis of dementia | | | in resident rooms including | |
| | | pecialized activity care | | | anything in disrepair or not be | ing |
| | programming. The | resident had a diagnosis of | | | homelike so they can be | |
| | Alzheimer's disease | e. The interventions included, | | | corrected. Administrator/Dept | |
| | but were not limited | d to, maintain the room as | | | Heads will round all rooms we | ekly |
| | homelike as possibl | le. | | | to ensure any room deficienci | es |
| | | | | | will be identified and corrected | d. |
| | 2. During an observ | vation, on 7/23/24 at 12:44 p.m., | | | QAPI meeting was held with the | he |
| | Resident 1 was lyin | g in bed. The resident had no | | | Executive Director, Director of | |
| | pictures, a clock, or | any personal items in her | | | Nursing, Assistant Director of | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/29/2024 155491 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE bedroom. Resident 1 indicated she did not like her Nursing, Unit Managers one, two, bedroom. and three, and Social Services, Memory Care Coordinator to During an observation, on 7/25/24 at 11:00 a.m., review the plan and findings. The Resident 1 was lying in bed. The resident had no action was completed by the pictures, a clock, or any personal items in her Executive Director on 7/30/24 bedroom. Resident 1 indicated she "hated" her How the corrective action(s) bedroom and did not feel like it was homelike. will be monitored to ensure the deficient practice will not Review of the record of Resident 1, on 7/25/24 at recur, i.e., what quality 11:50 a.m., indicated the resident's diagnoses assurance program will be put included, but were not limited to, Parkinson's into place. disease, chronic obstructive pulmonary disease Administrator/Dept Heads will (COPD), dementia, diabetes, atherosclerotic heart audit rooms 3X weekly for 6 disease, major depressive disorder, paranoid months to identify any deficiencies personality disorder, and conversion disorder relating to resident rooms. Audit with seizures. results will be shared with QAPI. QAPI meeting was held with the The plan of care for Resident 1, dated 4/13/22, Executive Director, MDS, Social indicated the resident resided on a secured Services, Director of Nursing, memory care unit due to the diagnosis of Assistant Director of Nursing, and dementia. The intervention included, but were not Unit Managers review audits, limited to, maintain the room as homelike as education, results, and findings. possible. The next QAPI meeting will be held on 8/22/24. Audited records The Annual Minimum Data Set assessment for will be reviewed by the Risk Resident 1, dated 4/4/24, indicated the resident Management/Quality Assurance was cognitively intact for daily decision making. Committee until such time consistent substantial compliance During an observation and interview with the has been achieved as determined Social Service Director (S.S.D.), on 7/26/24 at 11:55 by the committee. Audit results a.m., they agreed that Resident 18 and Resident will be shared by the Risk 1's bedrooms were not homelike. The S.S.D. Management/Quality Assurance indicated it was Social Services, Nursing, and Committee. 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.

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Facility ID: 000316

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTI A. BUILD B. WING | | nstruction 00 | (X3) DATE : COMPL 07/29/ | ETED | |
|--|---|---|-----------------|------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIEI | | 10 |)29 E 5 | DDRESS, CITY, STATE, ZIP COD STH STREET RSVILLE, IN 47331 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | II PRE TA | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | A Quarterly Minimum Data Set assessment, dated 7/4/24, indicated that Resident 75 was cognitively intact. | | | | | | |
| | at 1:29 p.m., Reside in her room had a la side. A napkin was | ion and interview, on 7/23/2024 ent 75 indicated that the blinds arge break on the right-hand placed over the opening and y have been broken for "some | | | | | |
| | 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. | | | | | | |
| | at 12:30 p.m., Residight does not work light out in her bath pulling the cord to before it turned on the sink the bathroc stated she had told | dent 38 indicated the over bed all the time and she has one aroom. She demonstrated her over bed light seven times. The right side of the light over om did not turn on. Resident 38 multiple staff about the lights have not been fixed. | | | | | |
| | | rd for Resident 64 was reviewed p.m. The medical diagnosis re. | | | | | |
| | | um Data Set Assessment, cated that Resident 64 was | | | | | |
| | _ | ion, on 7/24/24 11:05 a.m., the n Resident 64's bathroom was | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

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| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
|---|---|--|---------------------|--|----------------------|
| | PROVIDER OR SUPPLIER | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | noted to have unmare either side in the dry During a tour of the Administrator, on 7/ was not aware of the 75, Resident 38, or have them addressed A policy entitled, "It provided by the Are Services on 7/29/24 indicated, "The reclean, comfortable a 3.1-19(f)(5) 483.24(c)(1) Activities Meet Inte §483.24(c) Activities §483.24(c) (1) The on the comprehen plan and the prefeongoing program to choice of activities group and individuindependent activitinterests of and surand psychosocial encouraging both interaction in the comprehen the facility for the self-initiated activities activities ac | tched paint and two holes on ywall. It facility with the 1/26/24 2:38 p.m., indicated he issues as above for Resident Resident 64's room, but would do as soon as possible. Resident Rights", was at 2:10 p.m. The policy esident has a right to safe, and homelike environment" It facility must provide, based asive assessment and care exerces of each resident, and to support residents in their is, both facility-sponsored ual activities and ities, designed to meet the apport the physical, mental, well-being of each resident, independence and community. It is a support to the physical mental, well-being of each resident, independence and community. It is a support to the physical mental, well-being of each resident, independence and community. It is a support to the physical mental, well-being of each resident, independence and community. It is a support to the physical mental, well-being of each resident, independence and community. | | F679 What corrective action will b accomplished for those residents found to have beer affected by the deficient practice. | DATE 08/12/2024 |
| | Finding include: During an observati | ion and interview with | | Social Services completed psychosocial assessment on resident 1 to ensure no negati | ve |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|--|--|------------------------------------|-------|------------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | ETED |
| | | 155491 | B. WI | | | 07/29/ | |
| | | 100.00 | | _ | | 017207 | |
| NAME OF I | PROVIDER OR SUPPLIE | FR. | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | no (iban on bollia) | | | | 5TH STREET | | |
| MAJEST | IC CARE OF CON | NERSVILLE | | CONNE | ERSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY O | OR LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | Resident 1, on 7/2: | 3/24 at 12:44 p.m., they were | | | outcomes relating to the allege | ed | |
| | lying in bed, awal | ke, and staring at the ceiling. | | | deficiency. Activity staff provid | ling | |
| | Their television wa | as unplugged with no music, | | | in room activities to resident 1 | | |
| | books, magazines, | puzzles, daily chronicle, or any | | | daily. | | |
| | type of activity wa | as available for the resident. The | | | How other residents having | the | |
| | resident indicated | she did not like her room. | | | potential to be affected by th | e | |
| | | | | | same deficient practice will b | oe - | |
| | During an observa | tion and interview with | | | identified and what correctiv | е | |
| | Resident 1, on 7/2 | 5/24 at 11:00 a.m., they were | | | action(s) will be taken. | | |
| | lying in bed, awak | e, and staring at the ceiling. | | | All residents have the potentia | al to | |
| | Their television re | mained unplugged with no | | | be affected by the alleged defi | | |
| | music, books, mag | gazines, puzzles, daily chronicle, | | | practice. Administrator/Activity | | |
| | or any type of activ | vity was available for the | | | Director completed Activity | | |
| | resident. The resid | lent indicated she "hated" her | | | preference audit by 8/8/24 of a | all | |
| | room. The resident | t indicated she did not | | | residents with no additional | | |
| | necessarily like to | do activities with other people. | | | negative findings. | | |
| | | nerself and did her own thing. | | | What measures will be put in | nto | |
| | - | ed to tell the writer what her | | | place and what systematic | | |
| | favorite activity w | as. | | | changes will be made to | | |
| | | | | | ensure that the deficient | | |
| | Review of the reco | ord of Resident 1, on 7/25/24 at | | | practice does not recur. | | |
| | 11:50 a.m., indicat | ted diagnoses included, but were | | | Administrator/Activity Director | will | |
| | not limited to, Parl | kinson's disease, chronic | | | educate activity staff on provid | | |
| | obstructive pulmor | nary disease, dementia, | | | activities to all residents by | Ū | |
| | diabetes, atheroscl | erotic heart disease, major | | | 8/12/2024. Activity staff will be | ; | |
| | depressive disorde | er, paranoid personality | | | documenting when they provide | de | |
| | disorder, and conv | version disorder with seizures. | | | the in-room activities daily or | | |
| | | | | | documenting refusals when | | |
| | The Annual Minin | num Data Set assessment, dated | | | activities are being offered to | | |
| | 4/4/24, for Resider | nt 1 indicated the resident was | | | ensure compliance. QAPI med | eting | |
| | cognitively intact | for daily decision making. The | | | was held with the Executive | - | |
| | resident was consi | stent and reasonable. It was | | | Director, Director of Nursing, | | |
| | very important for | the resident to take care of her | | | Assistant Director of Nursing, | Unit | |
| | . – | gs and things. It was somewhat | | | Managers one, two, and three | | |
| | important to listen | to music, keep up with the | | | and Social Services, Memory | | |
| | - | gs with groups of people. It was | | | Coordinator to review the plan | | |
| | very important for her to conduct a favorite | | | | findings. This action was | | |
| | activity and go outside. | | | | completed by the Executive | | |
| | | | | | Director on 7/30/24. | | |
| | The plan of care for | or Resident 1, dated 9/14/23, | | | How the corrective action(s) | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE C A. BUILDING B. WING | construction 00 | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
|--|--|---|---------------------|---|--|
| | PROVIDER OR SUPPLIER | | 1029 E | ADDRESS, CITY, STATE, ZIP COD E 5TH STREET IERSVILLE, IN 47331 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION nt preferred to be engaged in | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) will be monitored to ensure | DATE |
| | independent self-dirinterventions included reading, provide dairight to decline activity activity. During an interview 7/26/24 at 2:20 p.m. Aides responsibility self-initiated activity. The Activity policy Nursing, on 7/29/24 facility would proviprogram to support activities. Individual would be designed to resident, as well as and psychosocial well. | rected activities. The ed watching television, ly chronical, respect resident's vity, praise resident's vities and resident needs reassurance to participate in with the Activity Director, on , indicated it was the Activity to ensure Resident 1 had les available in her room. provided by the Director of at 11:00 a.m., indicated the de an ongoing activity residents in their choice of l and independent activities o meet the interest of each support their physical, mental | | deficient practice will not recur, i.e., what quality assurance program will be pinto place. Audit tools and documentation be reviewed by Administrator monthly QAA meeting to ensure compliance. The daily provising in room activities or refusal documentation audits will be reviewed by the QAPI Commonthly until such time consistent substantial compliance in been achieved as determined the committee. QAPI meeting held with the Executive Direct MDS, Social Services, Direct Nursing, Assistant Director of Nursing, and Unit Managers audits, education, results, and findings. The next QAPI meet will be held on 8/22/24. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until statime consistent substantial compliance has been achieved determined by the committee Audit results will be shared by Risk Management/Quality Assurance Committee. | n will in ure on of ittee stent as I by I was tor, or of creview d ting ed ne uch |
| F 0684 SS=E Bldg. 00 | applies to all treatifacility residents. | a fundamental principle that ment and care provided to | | | |

| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|----------|--|------------------------------------|--------|------------|---|-----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | LETED |
| | | 155491 | B. W | ING | | 07/29/ | /2024 |
| NAME OF | DDOLUDED OF GUMPY TO | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF | PROVIDER OR SUPPLIEI | C | | 1029 E | 5TH STREET | | |
| MAJEST | TIC CARE OF CON | NERSVILLE | | CONNE | ERSVILLE, IN 47331 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCE | | DATE |
| | 1 | re that residents receive | | | | | |
| | | e in accordance with | | | | | |
| | professional standards of practice, the comprehensive person-centered care plan, | | | | | | |
| | and the residents' choices. | | | | | | |
| | | | F 00 | 584 | 1 F684 Actions taken for | | 08/12/2024 |
| | Based on observation | on, interview, and record | | | resident affected. | | 50.12.2021 |
| | | failed to administer residents' | | | Immediate action(s) ta | ıken | |
| | medication as ordered; notify the physician of a | | | | for residents #52, # 64, #45 a | nd# | |
| | weight gain, as ordered; clarify a resident's | | | | 14 were found to have been | | |
| | | nsure a resident's compression | | | affected by the alleged deficie | ency | |
| | stockings were in place, as ordered; and follow-up | | | | include: | | |
| | on a physician's order for gastrostomy tube | | | | Residents #52, # | - | |
| | removal for 1 of 1 resident reviewed for dialysis, 1 of 5 residents reviewed for unnecessary | | | | # 45 and #14 were assess by | | |
| | | resident reviewed for edema, | | | the Director of Nursing Serv for immediate concerns. No | | |
| | | reviewed for tube feeding. | | | identified at this time. | ii C | |
| | (Residents 14, 45, 5 | _ | | | identified at this time. | | |
| | (200100110) 11, 13, | -, -, -, -, | | | | | |
| | Findings include: | | | | 2. Identification of other | er | |
| | | | | | residents having the potenti | al | |
| | | ord for Resident 52 was | | | be affected was | | |
| | | 4 at 2:15 p.m. His diagnoses | | | accomplished by | | |
| | | not limited to, end stage renal | | | All residents who have an ord | | |
| | disease and hypoter | 181011. | | | compression hose, daily weig | | |
| | The dialysis care of | an indicated he required | | | and use of vasopressors have potential to be affected. 100% | | |
| | | onday, Wednesday and | | | audit of all residents was | O | |
| | • | facility at 6:00 a.m. and returned | | | completed by the Nursing | | |
| | 1 | The goal was for him to be free | | | Management Team including | | |
| | | related to dialysis. An | | | Assistant Director of Nursing, | Unit | |
| | | administer medications, as | | | Managers and/or designee, to | | |
| | ordered. | | | | ensure that each resident that | | |
| | | | | | have orders for compression | hose, | |
| | _ | ac output care plan, revised | | | daily weights and on a | | |
| | | he goal was for him to be free | | | Vasopressor for following MD | | |
| | • | and symptoms of cardiac | | | orders on 8/8/24. | | |
| | | ervention was to observe for | | | | | |
| | | cardiac dysfunction such as | | | No further concerns were | | |
| | decreased heart rate | e or blood pressure, initiated | | | identified. | | İ |

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | SURVEY | | |
|------------|---|----------------------------------|--|----------|---|--------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155491 | B. WI | | | 07/29/ | |
| | | 100101 | | | | 017207 | 202 . |
| NAME OF I | PROVIDER OR SUPPLIEF | 3 | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| TWINE OF I | NO VIDER OR SETTEME | | | 1029 E | 5TH STREET | | |
| MAJEST | IC CARE OF CONN | NERSVILLE | | CONNE | ERSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | 3/20/22. | | | | | | |
| | | | | | Actions taken/syste | ms | |
| | The physician's ord | ers indicated he had dialysis | | | put in place to reduce the ris | k | |
| | appointments three | times a week on Monday, | | | of future occurrence | | |
| | Wednesday, and Friday. The physician's orders | | | | Include: | | |
| | indicated to administer a 10 mg (milligrams) tablet | | | | | | |
| | of Midodrine one time a day every Monday, | | | | QAPI meeting was held with t | he | |
| | Wednesday, and Friday for low blood pressure | | | | Executive Director, Director of | | |
| | one hour prior to di | alysis, starting 10/18/23. There | | | Nursing, Assistant Director of | | |
| | was no parameter o | n the blood pressure | | | Nursing, Unit Managers one, t | wo, | |
| | indicating what con | stituted a low blood pressure. | | | and three, and Social Service | | |
| | There was another order to administer a 10 mg | | | | Memory Care Coordinator to | , | |
| | tablet of Midodrine every 12 hours as needed for | | | | review the plan and findings. | This | |
| | a systolic blood pressure equal to or less than 100 | | | | action was completed by the | | |
| | | rs, starting 3/28/24. There was | | | Executive Director on 7/30/24. | On | |
| | | pressure to be taken on | | | 8/6/2024, education was initial | - | |
| | non-dialysis days. | | | | and will continue until all RN/L | | |
| | | | | | /care team members have bee | | |
| | The July 2024 MAI | R (medication administration | | | educated on ensuring that | 21. | |
| | | e regularly scheduled | | | Physicians orders are being | | |
| | | administered on Wednesday, | | | followed. Nursing Manageme | nt | |
| | | 7/15/24. It indicated the as | | | Team including the Director of | | |
| | _ | was not administered at all in | | | Nursing, Assistant Director of | | |
| | | 4 thus far, but there were no | | | Nursing, Unit Managers. | | |
| | | ted blood pressure results for | | | Education completed on 8/12/ | 24 | |
| | | the clinical record verifying | | | Ladoation completed on 6/12/ | ∠ -⊤. | |
| | | lic blood pressure was not | | | 4. How the corrective | | |
| | - | n 100 and didn't require | | | | | |
| | administration. | 1 100 and didn't require | | | action(s) will be monitored to | , | |
| | administration. | | | | ensure the practice will not | | |
| | The 6/26/24 nurse r | practitioner note indicated | | | reoccur: | | |
| | _ | zed that blood pressure had | | | The Director of Nursing Assis | tant | |
| | | s and "discussion with nursing | | | The Director of Nursing, Assis | ıanı | |
| | - | reports SBP [systolic blood | | | Director of Nursing, and Unit | doily | |
| | | | | | Managers will randomly audit | ually | |
| | | less than 80 during treatment." | | | weight, compression hose | | |
| | | d Plan section of the note | | | application, and following | . 0 | |
| | | dodrine 10 mg the night before | | | Physician orders 3 x weekly | x 3 | |
| | | to the prn (as needed) morning | | | months then monthly for 2 | | |
| | | ne orders in this note did not | | | months, then Quarterly. Audi | ts | |
| | match Resident 52's | s above physician's orders or | | | will be reviewed by the QAPI | | |

PRINTED: 08/14/2024 FORM APPROVED

| CENTERS FOR | R MEDICARE & MEDIC | | | | OMB NO. 0938-039 |
|-------------|-----------------------|------------------------------------|-----------------|---|------------------|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED |
| | | 155491 | B. WING | · | 07/29/2024 |
| | | | | _ | |
| NAME OF F | PROVIDER OR SUPPLIEI | R | | ADDRESS, CITY, STATE, ZIP COD | |
| | | | | E 5TH STREET | |
| MAJEST | IC CARE OF CON | NERSVILLE | CONN | IERSVILLE, IN 47331 | |
| (X4) ID | SUMMADV | STATEMENT OF DEFICIENCIE | ID | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE | |
| | ` | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | | DATE |
| | July 2024 MAR. | | | Committee until such a time | |
| | | | | consistent substantial compli | |
| | | conducted with the DON | | has been achieved as detern | |
| | | ng) on 7/26/24 at 12:10 p.m. She | | by committee. Audit results | ; will |
| | | 52's Midodrine orders and | | be shared with QAPI. QAPI | |
| | | not sure what his Midodrine | | meeting was held with the | |
| | orders were suppos | sed to be; why the Midodrine | | Executive Director, MDS, So | cial |
| | was not administer | ed on 7/3/24 or 7/15/24; or why | | Services, Director of Nursing | , |
| | blood pressures we | ere not being obtained on | | Assistant Director of Nursing | , and |
| | non-dialysis days, l | but she would get clarification. | | Unit Managers review audit | s, |
| | | | | education, results, and findin | gs. |
| | 2. The clinical reco | ord for Resident 64 was reviewed | | The next QAPI will be held of | · |
| | on 7/29/24 at 10:48 | 3 a.m. The diagnoses included, | | 8/22/24.Audited records will l | |
| | | d to, congestive heart failure | | reviewed by the Risk | |
| | and edema. | | | Management/ Quality | |
| | | | | Assurance Committee until s | uch |
| | The at risk for fluid | l imbalance care plan, revised | | time consistent substantial | don |
| | | the goal was to remain free of | | compliance has been achie | yod |
| | | oad. Interventions were to | | as determined by the commit | |
| | | tions as ordered, initiated | | Audit results will be shared w | |
| | | thts as ordered/indicated and to | | | /IUI |
| | _ | | | the | |
| | | significant weight changes, | | Risk Management/Quality | |
| | initiated 10/24/23. | | | Assurance Committee | |
| | TEN 1 | 1 | | | |
| | | ders indicated to obtain daily | | 5. Corrective action | |
| | | he physician of a weight gain | | complete date:08/12/24 | |
| | - | nds in a day or 5 pounds in a | | | |
| | _ | 5/23. They indicated to | | | |
| | ` | g tablet of Metolazone one time | | | |
| | a day for a diuretic | , starting 6/12/24. | | | |
| | | | | | |
| | - | R indicated a 4.7 pound gain on | | | |
| | _ | evious day, a 5.8 pound gain on | | | |
| | | evious day, and a 7.8 pound | | | |
| | gain on 7/25/24 fro | om the previous day. There was | | | |
| | | he clinical record to indicate the | | | |
| | physician was infor | rmed of these over 3 pounds in | | | |
| | | There were no weights | | | |
| | | 4, 7/19/24, and 7/27/24 in the | | | |

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July 2024 MAR.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
|--|--|--|---------------------|---|---------------|
| | PROVIDER OR SUPPLIEF | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE COMPLETION |
| | called today with la natriuretic peptide-l failure]. Pro BNP w to increase Metolaz mg. Get daily weigh weight gain." | b results for Pro BNP [Brain blood test that detects heart was elevated, cardiologist wants one Tablet from 2.5 mg to 5 ht, call cardiologist if 3 lb | | | |
| | Metolazone was no mg, as indicated, in July 2024 MAR incomparts to receive 2.5 mg or and 7/29/24, after the state of the s | t increased from 2.5 mg to 5 the above verbal order. The licated Resident 64 continued f Metolazone 7/27/24, 7/28/24, ne verbal order to increase to 5 | | | |
| | 7/29/24 at 1:00 p.m verification the phy 64's daily weight ga 7/5/24, 7/7/24, or 7/proceed with chang 3. The clinical record on 7/24/24 at 2:17 plut were not limited (ventilator) status, of depression, morbid anxiety disorder, and The Quarterly Miniassessment for Residential and the procession of the procession of the procession of the quarterly Miniassessment for Residential of the procession of the proc | onducted with the DON on . She indicated there was no sician was notified of Resident in more than 3 pounds on /25/24, and she was going to ing the Metolazone order. rd for Resident 45 was reviewed o.m. The diagnoses included, d to, dependance on respirator chronic pain syndrome, (severe) obesity, generalized in unspecified cirrhosis of liver. mum Data Set (MDS) dent 45, dated 4/18/24, and was cognitively intact for ng. | | | |
| | at 1:30 p.m., indicatube (G-tube) that he removed. Resident | with Resident 45, on 7/23/24 ted he had a gastrointestinal te had been waiting to be 45 indicated that the g-tube d and it occasionally would | | | |

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AFQM11 Facility ID: 000316

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| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491 | r í | ILDING | ONSTRUCTION 00 | (X3) DATE COMPI 07/29 | LETED |
|--------------------------|---|---|-----|---------------------|--|-----------------------------|----------------------------|
| NAME OF P | PROVIDER OR SUPPLIE | | 3 | STREET A | ADDRESS, CITY, STATE, ZIP COD 5TH STREET | 31723 | |
| MAJEST | IC CARE OF CON | NERSVILLE | | | ERSVILLE, IN 47331 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | (X5) COMPLETION DATE |
| TAG | bleed. | R ESC IDENTIF TING INFORMATION | | IAG | | | DATE |
| | During an interview Resident 45, on 7/2 that the g-tube wow wrong. No redness the g-tube site. The physician order at 12:39 p.m., indicated to be removed. A proceed face sheet was faxed scheduling office. During an interview Respiratory, on 7/2 indicated the g-tube placed, on 6/28/24, resident's diagnosis re-written on 7/2/2. On 7/8/24, the order hospital central scheduling an interview Resident 45's diagraphysician's printed. During an interview Respiratory, on 7/2 the facility called can appointment with doctor] to remove the information, the make the appointment waiting to hear bac Corporate Director. | er was faxed again to the neduling office clarifying nosis, date of birth, and the | | | | | |
| | 45's g-tube remova | - | | | | | |
| | | ucted with the Regional Nurse 26/24 at 2:10 p.m., indicated | | | | | |

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Event ID:

AFQM11 Facility ID: 000316

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | SURVEY | |
|--|---|---|--------------------------------|-----------------------|---|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETE | | | ETED | |
| | | 155491 | B. WING | <u> </u> | | 07/29/2024 | |
| | | | STRE | EET A | DDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | t . | | | 5TH STREET | | |
| MAJESTI | IC CARE OF CONN | NERSVILLE | | | RSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CO | | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | \dashv | DEFICIENCE | | DATE |
| | | not have a policy for following The facility followed the | | | | | |
| | standards of practic | _ | | | | | |
| | summent of process | | | | | | |
| | An "Appropriate Use of Feeding Tubes policy" | | | | | | |
| | | ginal Nurse Consultant 2, on | | | | | |
| | 7/26/24 at 2:10 p.m | | | | | | |
| | - | ng tubes will be used only as | | | | | |
| | necessary to address | s malnutrition and en the resident's clinical | | | | | |
| | | is intervention medically | | | | | |
| | necessary". | is mervention medically | | | | | |
| | 4. The clinical record for Resident 14 was reviewed | | | | | | |
| | on 7/24/2024 at 1:2 | 0 p.m. The medical diagnosis | | | | | |
| | included chronic ob | estructive pulmonary disease. | | | | | |
| | | D. G. A | | | | | |
| | | mum Data Set Assessment, dicated that Resident 14 was | | | | | |
| | | nd needed assistance of setup | | | | | |
| | to limited for dressi | _ | | | | | |
| | | | | | | | |
| | A care plan, revised | d on 2/21/2024, indicated that | | | | | |
| | | paired cardiac function. An | | | | | |
| | | 5/12/2022, indicated for | | | | | |
| | Resident to utilize of | compression socks as ordered. | | | | | |
| | A physician order. | dated 3/16/2020, indicated for | | | | | |
| | | compression stockings | | | | | |
| | | ng and off in the evening for | | | | | |
| | edema. | | | | | | |
| | An int | haamistica on 7/22/2024 | | | | | |
| | | bservation, on 7/23/2024 at ed that Resident 14 was sitting | | | | | |
| | _ | his feet elevated. White tube | | | | | |
| | | d at the ankle and indented the | | | | | |
| | | ndicated that he had edema for | | | | | |
| | | ave not been placing his | | | | | |
| | - | ngs or ace wraps. He stated | | | | | |
| | - | comfortable" and that he | | | | | |
| | cannot get his comp | pression stockings on or place | 1 | | | | |

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Event ID:

AFQM11 Facility ID: 000316

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | ` ′ | | | | X3) DATE SURVEY | |
|--|---|---|---------------------------------|--------|--|-----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETED | | | ETED | |
| | | 155491 | B. W | ING | | 07/29/ | /2024 |
| | PROVIDER OR SUPPLIE | | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | 1 | ID | | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | ` | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IE | DATE |
| | them on his own. | | | | | | |
| | 11:05 a.m., indicate in his recliner with socks were wrinkle skin. Resident 14 in was unchanged, and compression stocki An interview and o Practical Nurse 3, of indicated that she direcord that Residen were administered, yet. She completed 14's swelling of plu indicated this was be | bbservation, on 7/25/2024 at ed that Resident 14 was sitting his feet elevated. White tube ed at the ankle and indented the edicated that he had edema that d they have not placed his engs all week. bbservation with Licensed on 7/25/2024 at 11:10 a.m., lid mark off the treatment at 14's compression stockings but she had not placed them an assessment of Resident as one pitting edema. She baseline for Resident 14 and tockings should have been in | | | | | |
| F 0690 SS=D Bldg. 00 | on 7/26/2024 at 2:1 specific policy for a facility would follo follow physician or contraindicated. 3.1-37(a) 483.25(e)(1)-(3) Bowel/Bladder Inc §483.25(e) Incont §483.25(e) (1) The resident who is composed by the specific powel on admissional assistance to mai or her clinical contractions. | Regional Nurse Consultant 1, 10 p.m., indicated there was not a following physician orders. The low the standards of practice to orders as written unless clinically continence, Catheter, UTI tinence. The facility must ensure that continent of bladder and on receives services and intain continence unless his dition is or becomes such a not possible to maintain. | | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE A. BUILDING B. WING | | | |
|--|---|---|--------------|--|-----------------------|
| | F PROVIDER OR SUPPLIE | | 1029 | T ADDRESS, CITY, STATE, ZIP COD E 5TH STREET NERSVILLE, IN 47331 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO | |
| TAG | §483.25(e)(2)For incontinence, bas comprehensive a ensure that- (i) A resident who an indwelling catt unless the resided demonstrates that necessary; (ii) A resident who indwelling catheter one is assessed f as soon as possitic clinical condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence. §483.25(e)(3) For incontinence, bas comprehensive a ensure that a resident a resident are sident as possitic direction as possitic direction as possitic direction. Based on observation review, the facility urinary catheter dragement of the continence of continence of the continence of the facility urinary catheter dragement of the continence | o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible. The a resident with fecal and the ed on the resident's assessment, the facility must dent who is incontinent of a propriate treatment and e as much normal bowel failed to ensure a resident's aimage bag and/or tubing antact with the floor for 1 of 2 for indwelling urinary | F 0690 | 1 F690 Actions taken for resident affected. Immediate action(s) to for resident # 33 that was four have been affected include: Resident #33 was assessed the Director of Nursing Serv for immediate concerns. No identified at this time. 2. Identification of other residents having the potential | ken nd to by ices ne |
| | 1 | x 2/ | I | | - |

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Event ID:

AFQM11 Facility ID: 000316

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|----------------------------------|--|--------|--------------------------------------|------------|------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPL | | | LETED | |
| | | 155491 | B. W | ING | | 07/29/2024 | |
| | | ı | <u> </u> | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | R | | | | | |
| ΜΔ ΙΕςΤ | IC CARE OF CONN | NERSVILLE | 1029 E 5TH STREET CONNERSVILLE, IN 47331 | | | | |
| IVIAJEST | - CANL OF COM | VEL COVIELE | | CONNE | -100 VILLE, IIN 47331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | NCY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | ATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | infections, and dyst | uria. | | | be affected was | | |
| | | | | | accomplished by | | |
| | | num Data Set Assessment, | | | All residents who have an ord | der | |
| | | licated that Resident 33 was | | | for Foley Catheters have the | | |
| | | impaired, had an indwelling | | | potential to be affected. 100% | 6 | |
| | | d needed extensive assistance | | | audit of all residents was | | |
| | of staff for toileting needs. | | | | completed by the Nursing | | |
| | | | | | Management Team including | | |
| | A urinary catheter care plan, revised on 2/23/2023, | | | | Assistant Director of Nursing, | | |
| | indicated that Resident 33 was at risk for | | | | Managers and/or designee, to | | |
| | complications and infection related to utilizing an | | | | ensure that each resident that | = | |
| | indwelling catheter for treatment of obstructive | | | | have orders for Foley Cathete | ers on | |
| | uropathy. | | | | 8/8/24. | | |
| | A physician order | dated 6/11/2024, indicated that | | | No further concerns were | | |
| | | d an indwelling catheter for | | | No further concerns were identified. | | |
| | obstructive uropath | _ | | | i identilied. | | |
| | oosii ucii ve uropaiii | .y. | | | 3. Actions taken/syste | me | |
| | An observation of I | Resident 33, on 7/23/2024 at | | | put in place to reduce the ris | | |
| | | d he was sitting in his | | | of future occurrence | , n | |
| | _ | nurses' station. This urinary | | | Include: | | |
| | 1 | s contacting the floor. | | | molauc. | | |
| | l line in the line | | | | QAPI meeting was held with t | he | |
| | An observation of F | Resident 33, on 7/26/2024 at | | | Executive Director, Director of | | |
| | | d that the urinary catheter | | | Nursing, Assistant Director of | | |
| | | anging off the side of the bed | | | Nursing, Unit Managers one, | | |
| | and contacting the | | | | two , and Social Services, | | |
| | | | | | Memory Care Coordinator to | | |
| | An observation and | l interview of Resident 33, on | | | review the plan and findings. | This | |
| | 7/26/2024 at 11:16 | a.m., indicated that his urinary | | | action was completed by the | | |
| | catheter bag was ha | anging off the side of his bed. | | | Executive Director on 7/30/24 | . On | |
| | Certified Nursing A | Assistant (CNA) 4 verified that | | | 8/6/2024, education was initia | ted | |
| | the bag was contact | ting the floor. She did not | | | and will continue until all RN/L | _PN | |
| | know how she shou | ald ensure the catheter was not | | | /care team members have bee | en | |
| | contacting the floor | r. | | | educated on ensuring that | | |
| | | | | | Physicians orders are being | | |
| | An interview with t | the Regional Nurse Consultant | | | followed. Nursing Manageme | ent | |
| | | 2:25 p.m., indicated that is the | | | Team including the Director of | f | |
| | current standard of | practice for the urinary | | | Nursing, Assistant Director of | | |
| | catheter tubing and | drainage bag to remain free of | | | Nursing, Unit Managers. | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491 | (X2) MULTIPLE C A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 07/29/2024 |
|--------------------------|---|--|-------------------------------------|---|--|
| | PROVIDER OR SUPPLIER | | 1029 E | ADDRESS, CITY, STATE, ZIP COD E 5TH STREET IERSVILLE, IN 47331 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 5.112 |
| | Catheters", was pro Consultant 1 on 7/2 indicated the follow catheter (urethral or | Appropriate Use of Indwelling wided by the Regional Nurse 16/2024 at 2:25 p.m. The policy ving, "Indwelling urinary r suprapubic) will be utilized in rrent standards of practice" | | 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing, Assist Director of Nursing, and Unit Managers will randomly audit Foley catheter tubing/bag tout the floor. 3 x weekly x 3 monthen monthly for 2 months, the Quarterly. Audits will be reviby the QAPI Committee until a time consistent substantial compliance has been achieved determined by committee. Auresults will be shared with QAPI meeting was held with a Executive Director, MDS, Soc Services, Director of Nursing, Assistant Director of Nursing, Unit Managers review audits education, results, and finding The next QAPI will be held or 8/22/24. Audited records will reviewed by the Risk Management/ Quality Assura Committee until such time consistent substantial compliants been achieved as determined by the committee. Audit results will be shared with the Risk Management/Quality Assurar Committee. 5. Corrective action complete date:08/12/24 | stant t for ching nths en ewed such ed as udit API. the cial and s, gs. n be nce ance nined lts |

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Event ID:

AFQM11 Facility ID: 000316

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| AND PLAN OF CORRECTION IDE | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | A. BU | (X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 07/29 | | | ETED |
|----------------------------|---|---|-------|---|---|---|----------------------------|
| | | 155491 | B. WI | NG | | 07/29/ | /2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .TE | (X5) COMPLETION DATE |
| F 0697 SS=D Bldg. 00 | 483.25(k) Pain Management §483.25(k) Pain M The facility must e management is pr require such servi professional stand comprehensive pe and the residents' Based on observation review, the facility resident receiving p administer narcotic with chronic pain for pain. (Resident 12) Findings include: The clinical record on 7/25/2024 at 1:1 included chronic pain A Quarterly Minim dated 5/20/2024, incognitively intact, r pain medication, an pain. A pain care plan, re Resident 12 was at chronic pain syndro intervention of adm ordered was dated 5 A physician order, or Resident 12 to receive three times a day ro | In Management. Insure that pain revided to residents who ces, consistent with lards of practice, the erson-centered care plan, goals and preferences. In interview, and record failed to routinely assess a pain medications and pain medication for a resident or 1 of 1 resident reviewed for In the medical diagnosis in syndrome. In Data Set Assessment, dicated that Resident 12 was eccived routine and as needed d was almost constantly in In wised on 3/8/2024, indicated risk for pain related to her one. A care planned dinistering medications as 5/3/2021. Indicated 7/11/2024, indicated for five tramadol 50 milligrams (mg) | F 00 | | 1 F697 Actions taken for resident affected. Immediate action(s) ta for resident #12 that was four have been affected include: Resident #12 was assessed the Director of Nursing Servifor immediate concerns. Not identified at this time. 2. Identification of othe residents having the potential be affected was accomplished by All residents who have an ord for narcotic medication have the potential to be affected. 100% audit of all residents who have ordered narcotics were complete by the Nursing Management Tincluding Assistant Director of Nursing, Unit Managers and/odesignee, 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. | ken nd to I by ices ne der he 6 eleted Feam | 08/12/2024 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE SURVEY | | |
|--|--|---------------------------------|--------------------------|----------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | | | |
| | | 155491 | B. WI | NG | | 07/29/2024 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | • | |
| | | | 1029 E 5TH STREET | | | | |
| MAJEST | IC CARE OF CONN | NERSVILLE | | CONNE | ERSVILLE, IN 47331 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE | |
| | | ive Tylenol 650 mg by mouth | | | | | |
| | every six hours rou | tinely for pain. | | | 3. Actions taken/syste | | |
| | During on interview | y, on 7/23/2024 at 12:55 p.m., | | | put in place to reduce the ris of future occurrence | SK | |
| | _ | ed that last week she went | | | Include: | | |
| | without her pain medication for two days. During | | | | include. | | |
| | _ | vas elevated, but it did not | | | QAPI meeting was held with t | he | |
| | keep her from doing her usual routine. Family | | | | Executive Director, Director of | | |
| | Member was present during the interview. He | | | | Nursing, Assistant Director of | | |
| | indicated Resident 12 appeared uncomfortable | | | | Nursing, Unit Managers one, t | | |
| | those two days when he was visiting and that the | | | | and three, and Social Service | | |
| | staff told him the facility could not get the pain | | | | Memory Care Coordinator to | | |
| | medication because of the "outage". | | | | review the plan and findings. | This | |
| | | | | | action was completed by the | | |
| | _ | 2024 medication administration | | | Executive Director on 7/30/24 | . On | |
| | | 12 indicated that she did | | | 8/6/2024, education was initia | | |
| | | Tylenol as ordered, but not | | | and will continue until all RN/L | | |
| | | tramadol for four doses as | | | /care team members have bee | en | |
| | follows: | | | | educated on ensuring that | | |
| | 7/10/2024 6 00 | | | | Physicians orders are being | | |
| | 7/18/2024 - 6:00 p.i | | | | followed. Nursing Manageme | | |
| | 7/19/2024 - 7:00 a.i | | | | Team including the Director of | | |
| | 7/19/2024 - 3:00 p.i | | | | Nursing, Assistant Director of | | |
| | 7/19/2024 - 6:00 p.i | m. | | | Nursing, Unit Managers. | 204 | |
| | A rounding docume | ent, dated 7/19/2024, indicated | | | Education completed on 8/12/ | ∠ 4 . | |
| | _ | aged with tramadol." | | | 4. How the corrective | | |
| | pain was mun | | | | action(s) will be monitored to | . | |
| | No pain scale or ass | sessment were documented | | | ensure the practice will not | | |
| | _ | at 5:36 p.m., and 7/20/2024 at | | | reoccur: | | |
| | 6:11 a.m. | - | | | | | |
| | | | | | The Director of Nursing, Assis | tant | |
| | A policy, entitled "l | Pain Management", was | | | Director of Nursing, and Unit | | |
| | | gional Nurse Consultant on | | | Managers will randomly audit | for | |
| | _ | .m. The policy indicated the | | | need for ordering of Narcotics | to | |
| | _ | lents receiving routine pain | | | ensure that medication is | | |
| | | be assessed each shift by the | | | available. 3 x weekly x 3 | | |
| | | ng round and/or medication | | | months then monthly for 2 | | |
| | pass" | | | | months, then Quarterly. Audi | its | |
| | l | | | | will be reviewed by the QAPI | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/14/2024 FORM APPROVED

| CENTERS FOI | R MEDICARE & MEDIC | | | | OMB NO. 0938-039 |
|--|---|---|---|--|---------------------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING | | | (X3) DATE SURVEY COMPLETED 07/29/2024 | | |
| | PROVIDER OR SUPPLIER | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) Committee until such a time | (X5) COMPLETION DATE |
| | 3.1 37(a) | | | consistent substantial compliance that substantial compliance has been achieved as determing by committee. Audit results with be shared with QAPI. QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, Assista | ined ill cial and s. be nce nce |
| F 0776 SS=D Bldg. 00 | §483.50(b) Radiol services. §483.50(b)(1) The obtain radiology a to meet the needs facility is responsitimeliness of the s (i) If the facility pro | Diagnostic Services ogy and other diagnostic facility must provide or nd other diagnostic services of its residents. The pole for the quality and ervices. Ovides its own diagnostic ces must meet the | | | |

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applicable conditions of participation for hospitals contained in §482.26 of this

Event ID:

AFQM11 Facility ID: 000316

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | | | |
|--|---|--|---|----------------|---|-------------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | A. BUILDING 00 | | | COMPLETED | |
| | | 155491 | B. WI | NG | | 07/29/ | 2024 | |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331 | | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | diagnostic service agreement to obta provider or supplie these services und Based on observation review, the facility scheduling a resider (computerized tomo procedure that uses create detailed image | in these services from a ser that is approved to provide der Medicare. on, interview, and record failed to timely follow-up on at's appointment for a CT ography-diagnostic imaging x-rays and computers to ges of the inside of the body) ents reviewed for skin | F 07 | 776 | 1 F776 Actions taken for resident affected. Immediate action(s) ta for resident #52 that was foundave been affected include: Resident #52 was assessed the Director of Nursing Servi for immediate concerns. No identified at this time. | d to by ices | 08/12/2024 | |
| | on 7/26/24 at 2:15 p but were not limited stage renal disease. An observation and with Resident 52 or lying in bed in his re was supposed to have the facility never for the appointment wo The physician's order scan of the spine with cervical, lumbar, and hospital provider, etc. The 7/10/24 order in "New order received a CT scan of the spine | ers indicated a referral for a CT thout contrast including d thoracic spine with a local | | | 2. Identification of othe residents having the potential be affected was accomplished by All residents who have an ordeneed for appointment for outsifacility Radiology/ Diagnostic Services have the potential to affected. 100% audit of all residents was completed by the Nursing Management Team including Assistant Director of Nursing, Unit Managers and/odesignee, to ensure that each resident that have an order for appointment are followed until appointment has been made woutside agencies. No further concerns were identified. | er or ide be be ne r an | | |
| | | f local provider] central | | | 3 Actions taken/syste | ms | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
|--|--|---|---------------------|--|--|
| | ROVIDER OR SUPPLIER | | 1029 E | ADDRESS, CITY, STATE, ZIP COD E 5TH STREET ERSVILLE, IN 47331 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | (X5) COMPLETION DATE |
| | | te included a fax and phone | | put in place to reduce the ris | |
| | indicate a CT scan a follow-up with the laws sent on 7/10/24 An interview was concept (Director of Nursing indicated the process was to call the local they needed an appointment or the provider. The an appointment or the analy additional inforto schedule the appointment of any additional inforto schedule the appointment of the provider. They needed a diag | onducted with the DON g) on 7/26/24 at 11:06 a.m. She is for scheduling CT scans provider to let them know ointment and send the order provider would call back with to let them know if they needed mation. She knew staff called ointment, but there was no follow-up before now. She icheduling at the local provider 2's CT scan referral was sent. mosis code, so they were lay, on 7/26/24, and get the | | Include: QAPI meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers one, and three, and Social Service Memory Care Coordinator to review the plan and findings, action was completed by the Executive Director on 7/30/24 8/6/2024, education was initial and will continue until all RN/I /care team members have be 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 4. How the corrective action(s) will be monitored to the security of th | f two, ces, This . On ted _PN en ent f |
| | | | | ensure the practice will not reoccur: The Director of Nursing, Assis | stant |
| | | | | Director of Nursing, and Unit Managers will audit for need to scheduling of outside of facilitic Radiology/Diagnostic Service x weekly x 3 months then most for 2 months, then Quarterly. Audits will be reviewed by the QAPI Committee until such a time consistent substantial | or y for s. 3 nthly |
| | | | | compliance has been achieve | ed as |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | COM | E SURVEY PLETED 9/2024 |
|----------------------------|---|---|--|---|---|------------------------------|
| | PROVIDER OR SUPPLIER | | 1029 E | ADDRESS, CITY, STATE, ZIP (5TH STREET ERSVILLE, IN 47331 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE DEFICIENCY) | RRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE |
| F 0791 | 483.55(b)(1)-(5) | | | determined by common results will be shared QAPI meeting was hexecutive Director, MI Services, Director of Nassistant Properties and Capital Director of Nassistant Properties of Nassistant | with QAPI. neld with the DS, Social Nursing, Nursing, and w audits, d findings. held on ords will be Assurance time compliance determined dit results e Risk Assurance | |
| F 0791 SS=D Bldg. 00 | §483.55 Dental So The facility must a routine and 24-ho §483.55(b) Nursin The facility- §483.55(b)(1) Musoutside resource, §483.70(g) of this services to meet t | ssist residents in obtaining ur emergency dental care. g Facilities. st provide or obtain from an in accordance with part, the following dental he needs of each resident: services (to the extent State plan); and | | | | |

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Event ID:

AFQM11 Facility ID: 000316

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/29/2024 | | | | ETED | |
|---|--|---|------|---------------|--|--------|--------------------|
| | | 100401 | В. W | _ | DDDFGG GITY GTATE ZID GOD | 011231 | 2024 |
| NAME OF F | PROVIDER OR SUPPLIER | ₹ | | | ADDRESS, CITY, STATE, ZIP COD 5TH STREET | | |
| MAJESTIC CARE OF CONNERSVILLE | | | | | ERSVILLE, IN 47331 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` · | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION DATE |
| | §483.55(b)(2) Must requested, assist (i) In making apportion (ii) By arranging for the dental service §483.55(b)(3) Must refer residents with for dental services within 3 days, the documentation of resident could still while awaiting derextenuating circurdelay; §483.55(b)(4) Must hose circumstant damage of dentur responsibility and for the loss or dand determined in acc to be the facility's §483.55(b)(5) Must eligible and wish the reimbursement of | st, if necessary or if the resident- pintments; and or transportation to and from s locations; st promptly, within 3 days, th lost or damaged dentures s. If a referral does not occur facility must provide what they did to ensure the I eat and drink adequately intal services and the mstances that led to the st have a policy identifying these when the loss or these is the facility's may not charge a resident | | | | | |
| | Based on observation | on, interview and record | F 0' | /91 | F791 | | 08/12/2024 |
| | | failed to ensure a resident was | | | What corrective action will be | Э | |
| | | ntal services for 1 of 4 for dental services. (Resident | | | accomplished for those residents found to have beer | 1 | |
| | 1) | , | | | affected by the deficient | | |
| | Findings include: | | | | practice. Resident 1 was added to the li to be seen by dentist on 8/20/2 | 24. | |
| | During an observati | ion and interview with | | | How other residents having t | he | |

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Event ID: AFQM11 Facility ID: 000316

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | r í | | | (X3) DATE SURVEY | |
|--|--|---|-------|---------------------------|---|------------------|----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155491 | B. W | ING | | 07/29/2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | 5TH STREET | | |
| MAJEST | IC CARE OF CON | NERSVII I E | | | ERSVILLE, IN 47331 | | |
| | 10 07 11 12 01 001 11 | TENOVICEE | | | 1 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | re COM | IPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| | · · · · · · · · · · · · · · · · · · · | 5/24 at 11:00 a.m., she indicated | | | potential to be affected by the | | |
| | | her to eat because she did not | | | same deficient practice will be | | |
| | 1 | e resident indicated she would | | | identified and what correctiv | е | |
| | | es. The resident was observed | | | action(s) will be taken. | | |
| | to have no lower or | r upper teeth. | | | All residents have the potentia | | |
| | | | | | be affected by the alleged def | | |
| | | rd of Resident 1, on 7/25/24 at | | | practice. An entire house audi | í | |
| | | ed the resident's diagnoses | | | was conducted by the Social | _ | |
| | | not limited to, Parkinsonism, | | | Service Director and Memory | | |
| | | pulmonary disease, dementia, | | | Facilitator by 8/8/24 to ensure | | |
| | · · | erotic heart disease, major | | | all residents had routine denta | 1 | |
| | - | r, paranoid personality | | | services according to their | | |
| | disorder, and conversion disorder with seizures. | | | | preferences and were added t | o be | |
| | | 5 | | | seen by dentist if needed. | | |
| | | num Data Set assessment for | | | What measures will be put in | to | |
| | | 4/4/24, indicated the resident | | place and what systematic | | | |
| | | act for daily decision making. | | | changes will be made to | | |
| | The resident was ed | dentulous (no natural teeth). | | | ensure that the deficient | | |
| | D | 'd G ' 1 G ' 1 | | | practice does not recur. | | |
| | - | w with Social Services 1, on | | | Administrator/Dept Heads pro | /ided | |
| | | m., indicated Resident 1 had not | | | education by 8/12/24 for staff | | |
| | | June 2023. The dentist made | | | notifying social services when | | |
| | _ | resident to get dentures at | | | there is a dental need. In addi | | |
| | | ures were not made because hear from the Power of | | | social services will speak with | | |
| | | ocial Services would be | | | residents or family members in | | |
| | • • • | owing up with the POA and | | | their quarterly care plan meeti | ~ | |
| | - | nt now has an appointment for | | | to update any dental preference they may have. QAPI meeting | | |
| | next month. | it now has an appointment for | | | 1 | | |
| | next month. | | | | held with the Executive Direct | , וכ | |
| | The Dental policy | provided by the Director of | | | Director of Nursing, Assistant Director of Nursing, Unit Mana | ngers | |
| | | 4 at 1:15 p.m., indicated the | | | one, two, and three, and Socia | - | |
| | _ | in routine dental services. | | | Services, Memory Care | " | |
| | lacinty would obta | in routine dentar services. | | | Coordinator to review the plan | and | |
| | 3.1-24(a)(1) | | | | findings. This action was | | |
| | 5.1 2 i(u)(1) | | | | completed by the Executive | | |
| | | | | | Director on 7/30/24. | | |
| | | | | | D.130(01 011 1/30/24. | | |
| | | | | | How the corrective action(s) | | |
| | | | | | will be monitored to ensure t | he | |

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/14/2024 FORM APPROVED

| CENTERS FOR | R MEDICARE & MEDIC | | | | | OM | IB NO. 0938-039 |
|----------------------------|--|--|-------|--|---|---|----------------------------|
| | OT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491 | A. BU | 2) MULTIPLE CONSTRUCTION A. BUILDING OO 3. WING | | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
| | PROVIDER OR SUPPLIER | | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | | | | | deficient practice will not recur, i.e., what quality assurance program will be pinto place. Administrator/Social Services audit 3 residents weekly for 1 weeks to ensure they have rodental services per their preferences. Results of these audits will be brought to QAA reviewed by the Administrator QAPI meeting was held with the Executive Director, MDS, Social Services, Director of Nursing, Assistant Director of Nursing, Unit Managers review audits, education, results, and finding The next QAPI meeting will be held on 8/22/24. Audited recomillation of the Risk Management/Quality Assurant Committee until such time consistent substantial compliants been achieved as determined by the committee. Audit results will be shared by the Risk Management/Quality Assurant Committee. | will 2 utine and r. the cial and gs. e rrds ace ance ance sined ts | |
| F 0842 SS=D Bldg. 00 | §483.20(f)(5) Res (i) A facility may n is resident-identifia (ii) The facility ma resident-identifiab accordance with a | - Identifiable Information ident-identifiable information. ot release information that | | | | | |

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information except to the extent the facility

itself is permitted to do so.

Event ID:

AFQM11 Facility ID: 000316

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491 | | ľ | JILDING | NSTRUCTION 00 | (X3) DATE COMPI 07/29 | LETED | |
|---|--|--|---------|---------------------|---|------------|----------------------------|
| | PROVIDER OR SUPPLIEI | | | 1029 E | DDRESS, CITY, STATE, ZIP COD 5TH STREET RSVILLE, IN 47331 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | E RIATE | (X5) COMPLETION DATE |
| | professional stand facility must main each resident that (i) Complete; (ii) Accurately doddii) Readily access (iv) Systematically \$483.70(i)(2) The confidential all information resident's records regardless of the the records, exce (i) To the individuo representative who law; (ii) Required by Law; (iii) For treatment operations, as percompliance with 4 (iv) For public hear abuse, neglect, or oversight activities proceedings, law organ donation pure or to coroners, and to a health or safety a compliance with 4 \$483.70(i)(3) The medical record into destruction, or uniferent safety and safe | ccordance with accepted dards and practices, the tain medical records on the tare-cumented; sible; and yorganized facility must keep cormation contained in the standard of the property of the present the permitted by applicable aw; apayment, or health care remitted by and in the standard of the property of the proper | | | | | |

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Event ID:

AFQM11 Facility ID: 000316

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| i ´ | | | | | (X3) DATE SURVEY | , | |
|----------|----------------------|--|---------|-----|--|-------------------------|--------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | ING | 00 | COMPLETED 07/20/2024 | |
| | | 155491 | B. WING | | | 07/29/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | ₹ | | | ODRESS, CITY, STATE, ZIP COD STH STREET | | |
| MAJEST | IC CARE OF CON | NERSVILLE | | | RSVILLE, IN 47331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID |) | PROVIDER'S PLAN OF CORRECTION | (| X5) |
| PREFIX | , i | ICY MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | E | LETION |
| TAG | † | R LSC IDENTIFYING INFORMATION n the date of discharge | TA | AG | DETCENCT) | D.F | ATE |
| | | requirement in State law; or | | | | | |
| | | years after a resident | | | | | |
| | reaches legal age | | | | | | |
| | | | | | | | |
| | - ',',' | medical record must | | | | | |
| | contain- | nation to identify the | | | | | |
| | resident; | nation to identify the | | | | | |
| | · · | e resident's assessments; | | | | | |
| | · ' | ensive plan of care and | | | | | |
| | services provided | | | | | | |
| | ` ' | any preadmission | | | | | |
| | | sident review evaluations and | | | | | |
| | | onducted by the State; | | | | | |
| | professional's pro | urse's, and other licensed | | | | | |
| | | diology and other diagnostic | | | | | |
| | | is required under §483.50. | | | | | |
| | | | F 0842 | | 1 F 842 Actions taken for | 08/1 | 2/2024 |
| | | and record review, the facility | | | resident affected. | | |
| | | treatments were completed, or | | | Immediate action(s) ta | | |
| | | to document if enteral feeding or refused, for 1 of 23 residents | | | for resident # c that was found have been affected include: | io | |
| | | nentation (Resident C). | | | Resident #C has | | |
| | | , , | | | been discharged from facility | <i>,</i> . | |
| | Finding include: | | | | - | | |
| | | 1 20 11 22 -75 | | | 2. Identification of othe | | |
| | | rd of Resident C, on 7/26/24 at | | | residents having the potentia | ı l | |
| | _ | If the diagnoses included, but the diagnoses included in | | | be affected was | | |
| | | gia, dependence on respirator | | | accomplished by All residents who refuse | | |
| | | neuromuscular dysfunction, | | | treatments have the potential | o be | |
| | | astrostomy (g-tube) status. | | | affected. Audit of all residents | | |
| | | | | | completed by the Nursing | | |
| | | w with the Corporate Director of | | | Management Team including | | |
| | | 9/24 at 2:42 p.m., he verified the | | | Assistant Director of Nursing, | Jnit | |
| | _ | ts were not documented as | | | Managers and/or designee, to | | |
| | _ | ed on the May 2024 Treatment cord (TAR) and verified that the | | | ensure that each resident that have noted to have refusal of | | |

| f ´ | | | ì í | | ONSTRUCTION | (X3) DATE SURVEY |
|----------------|-----------------------|---|------|---------------------------------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | UILDING | 00 | COMPLETED |
| | | 155491 | B. W | TING | | 07/29/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | • | | ADDRESS, CITY, STATE, ZIP COD | |
| | | | | | 5TH STREET | |
| MAJEST | IC CARE OF CONN | IERSVILLE | | CONNE | ERSVILLE, IN 47331 | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION |
| TAG | | LISC IDENTIFYING INFORMATION ng was not documented as | | TAG | treatments have been documents | DATE |
| | provided or refused | _ | | | on 8/8/24. | ented |
| | provided of refused | • | | | 011 0/0/24. | |
| | The May 2024 TAF | R for Resident C indicated | | | No further concerns were | |
| | Dakins (1/2 strengtl | n) external solution to left | | | identified. | |
| | I | Apply wound cleanser, | | | | |
| | | luffed gauze, and cover with an | | | 3. Actions taken/syste | |
| | ABD (abdominal) p | | | | put in place to reduce the ris | k |
| | | reatment was completed, or | | | of future occurrence | |
| | | for day shift and nightshift; 31/24 for day shift; and 5/28/24 | | | Include: | |
| | for nightshift. | 31/24 for day shift; and 3/28/24 | | | QAPI meeting was held with t | ho |
| for nightsmit. | | | | Executive Director, Director of | | |
| | The May 2024 TAF | R for Resident C indicated | | | Nursing, Assistant Director of | |
| | | n) external solution to the right | | | Nursing, Unit Managers one, | |
| | | Apply wound cleanser, | | | and three, and Social Service | |
| | Dakins moistened f | luffed gauze, and cover with an | | | Memory Care Coordinator to | · |
| | ABD pad. There wa | as no documentation the | | | review the plan and findings. | This |
| | _ | pleted, or refused, for 5/19/24 | | | action was completed by the | |
| | 1 | ghtshift; 5/20/24, 5/21/24 and | | | Executive Director on 7/30/24 | |
| | 5/31/24 for day shif | t; and 5/28/24 for nightshift. | | | 8/6/2024, education was initia | |
| | The May 2024 TAE | R for Resident C indicated to | | | and will continue until all RN/L /care team members have be | |
| | I - | foot with wound cleanser, | | | educated on ensuring that | S11 |
| | _ | leave open to air two times a | | | Physicians orders are being | |
| | | There was no documentation | | | followed. Nursing Manageme | nt |
| | l - | ompleted, or refused, for | | | Team including the Director of | |
| | 5/4/24, 5/7/24, 5/9/2 | 24, 5/11/24, 5/12/24, 5/15/24, | | | Nursing, Assistant Director of | |
| | | for day shift; and 5/8/24, | | | Nursing, Unit Managers. | |
| | 5/12/24, 5/13/24, 5/ | 14/24, 5/15/24 for evening shift. | | | Education completed on 8/12/ | 24. |
| | The May 2024 TAE | R for Resident C indicated to | | | 4. How the corrective | |
| | I - | cleanser, apply calcium | | | action(s) will be monitored to | |
| | | with a border dressing two | | | ensure the practice will not | |
| | 1 - | ght lateral leg. There was no | | | reoccur: | |
| | | reatment was completed, or | | | | |
| | refused, for 5/7/24, | 5/9/24, 5/11/24, 5/12/24, | | | The Director of Nursing, Assis | tant |
| | | 18/24 for day shift; and 5/8/24, | | | Director of Nursing, and Unit | |
| | 5/12/24, 5/13/24, 5/ | 14/23, 5/15/24 for evening shift. | | | Managers will randomly audit | |
| | | | | | refusal documentation. 3 x we | ekly |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) I | | | (X3) DATE | SURVEY | |
|--|----------------------|------------------------------------|-------|-----------------------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | COMPLETED | |
| | | 155491 | B. W | ING | | 07/29/2024 | |
| | | l . | | CTDEET / | ADDRESS CITY STATE ZID COD | l | |
| NAME OF P | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP COD 5TH STREET | | |
| MAIEST | IC CARE OF CONN | JERSVII I E | | | ERSVILLE, IN 47331 | | |
| IVIAJEST | OARE OF CONI | NENGVILLE | | COMME | -NOVILLE, IIN 4/331 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | R for Resident C indicated to | | | x 3 months then monthly for 2 | | |
| | | l cleanser, apply collagen to | | | months, then Quarterly therea | fter. | |
| | wound, and cover v | vith ABD pad to the right | | | Audits will be reviewed by the | | |
| | elbow. There was n | o documentation the treatment | | | QAPI Committee until such a | | |
| | | refused, for 5/4/24, 5/7/24, | | | time consistent substantial | | |
| | | 2/24, 5/15/24, 5/16/24, 5/18/24 | | | compliance has been achieve | | |
| | 1 | /8/24, 5/12/24, 5/13/24, 5/14/24, | | | determined by committee. A | udit | |
| | 5/15/24 for evening | shift. | | | results will be shared with QA | | |
| | | | | | QAPI meeting was held with the | | |
| | 1 | R for Resident C indicated to | | | Executive Director, MDS, Soc | ial | |
| | | wound with wound cleanser, | | | Services, Director of Nursing, | | |
| | | cover two times a day. There | | | Assistant Director of Nursing, | | |
| | | ion the treatment was | | | Unit Managers review audits | , | |
| | 1 - | ed, for 5/4/24, 5/7/24, 5/9/24, | | | education, results, and finding | S. | |
| | | /15/24, 5/16/24, 5/18/24 for day | | | The next QAPI will be held on | | |
| | | 12/24, 5/13/24, 5/14/24, 5/15/24 | | | 8/22/24. Audited records will b | e | |
| | for evening shift. | | | | reviewed by the Risk | | |
| | | | | | Management/ Quality | | |
| | | R for Resident C indicated to | | | Assurance Committee until su | ch | |
| | | right buttock and right | | | time consistent substantial | | |
| | | d cleanser, apply alginate, and | | | compliance has been achiev | | |
| | | o documentation the treatment | | | as determined by the committe | ee. | |
| | _ | refused, for 5/9/24, 5/11/24, | | | Audit results will be shared wi | | |
| | | /16/24 for day shift; and 5/8/24, | | | the Risk Management/Qualit | у | |
| | 5/12/24, 5/13/24, 5/ | /14/24, 5/15/24 for evening shift. | | | Assurance Committee | | |
| | | | | | | | |
| | · · | R enteral feed order indicated | | | 5. Corrective action comp | olete | |
| | | nave g-tube feeding formula at | | | date:08/12/24 | | |
| | | very hour for 12 hours. There | | | | | |
| | | ion the resident received the | | | | | |
| | | , the feeding formula for 5/9/24, | | | | | |
| | 5/11/24, 5/19/24. | | | | | | |
| | TEL 1 | 12 21 11 3 | | | | | |
| | | policy provided by the | | | | | |
| | | ident of Clinical Services, on | | | | | |
| | • | ., indicated each resident record | | | | | |
| | | curate representation of the | | | | | |
| | _ | of the resident to include | | | | | |
| | accurate and timely | documentation. | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024 FORM APPROVED OMB NO. 0938-039

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 07/29/2024 | |
|---------|---------------------|---|--|--------|--|---------------------------------------|------------|
| | ROVIDER OR SUPPLIER | | | 1029 E | ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | 3.1-50(a)(1) | | | | | | |
| | 3.1-50(a)(2) | | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AFQM11 Facility ID: 000316 If continuation sheet Page 35 of 35