STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 00 B. WING	01/18/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00425661. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00415678 completed on December 4, 2023. Complaint IN00425661- Federal/state deficiencies related to the allegations are cited at F659. Survey dates: January 17, 18, 2024. Facility number: 011049 Provider number: 155670 AIM number: 200258520 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 8 Medicaid: 67 Other: 16 Total: 91 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 19, 2024.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective January 30, 2024, to the complaint survey completed on January 18, 2024. We respectfully request a paper review and will provide any additional information requested.	
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Thompson	Executive Director	01/29/2024

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

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	(ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed. The correct dose of a resident's pain medication was not given. (Resident B) Finding includes: On 1/17/24 at 9:54 a.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, cluster headache syndrome, unspecified, intractable, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, epilepsy intractable, without status epilepticus. An admission MDS (Minimum Data Set) assessment dated 11/20/23, indicated Resident B's cognition was intact, pain frequency almost constantly, effects sleep and activities, pain 8 on scale. Resident B admitted to the facility on 11/13/23 and expired at the facility on 11/26/23. Care plans were reviewed and included, but were not limited to: [name] is at risk for pain due to encephalopathy, left hemiplegia, epilepsy, chronic headaches. Interventions included, but were not limited to: Administer medication as ordered, date initiated 11/14/23. [name] is receiving [name] hospice services, interventions included, but were not limited to: observe and assess [name] for signs of pain, distress or discomfort, administer medications and treatments as ordered and notify physician and hospice of unrelieved or worsening pain, discomfort or distress, date initiated 11/18/23.	F 0659	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B expired 11/26/2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. 100% medication and treatment cart audit completed 1/26/24 to ensure all medications ordered were in stock and accurate. DNS/ED will meet with pharmacy provider (Medscripts) on 1/26/24 to go through root cause analysis on pharmacy practice requiring escripts. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on the Medication Administration Policy and Medication Reordering Process and following physician orders/plan of care by the DNS/designee on 1/19/24 and 1/26/24. All nursing staff to complete skills	01/30/2024

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	Physicians orders for November 2023 were reviewed and included, but were not limited to: Morphine sulfate (concentrate) oral solution 20 mg/ml (milligram/milliliter) give 0.5 ml by mouth every 30 minutes as needed for pain/dyspnea contact hospice prior to giving 7th dose in a given day, order date 11/14/23. Morphine sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate) give 0.25 ml by mouth every 6 hours for pain/restlessness, order date 11/17/23, discontinued date 11/21/23. Morphine sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate) give 0.5 ml by mouth every 4 hours for pain/restlessness, order date 11/21/23. Morphine sulfate oral solution 10 mg/5 ml (morphine sulfate) give 1 ml by mouth every 2 hours as needed for pain, order date 11/13/23, discontinued date 11/14/23. Morphine sulfate (concentrate) solution 20 mg/ml give 0.5 milliliter by mouth every 4 hours as needed for pain, order date 11/13/23, discontinued date 11/14/23. The EMAR (Electronic Medication Administration Record) was reviewed for November 2023 and included, but was not limited to: Morphine sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate) give 0.5 ml by mouth every 4 hours for pain/restlessness, order date 11/21/23. Given on the following dates:		validations on 1/29/24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place;** QAPI tool Medication Cart audit will be completed weekly x 4 weeks, bimonthly x 2 and monthly x 4 months by DNS/designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. QAPI tool MAR/Medication Audit will be completed daily x 4 weeks, bimonthly x 2 months and monthly x 4 months by DNS/designee. If 100% threshold is not achieved, an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	11/21- 5:00 p.m.- pain level 8 11/21- 9:00 p.m.- pain level 8 11/22- 1:00 a.m.- pain level 4 11/22- 5:00 a.m.- pain level 4 11/22- 9:00 a.m.- pain level 8 11/22- 1:00 p.m.- pain level 9 11/22- 5:00 p.m.- pain level 9 11/22 9:00 p.m.- pain level 6 11/23- 1:00 a.m.- pain level 6 11/23- 5:00 a.m.- pain level 4 11/23- 9:00 a.m.- pain level 10 11/23- 1:00 p.m.- pain level 0 11/23- 5:00 p.m.- pain level 0 11/23- 9:00 p.m.- pain level 8 11/24- 1:00 a.m.-pain level 0 11/24- 5:00 a.m.- pain level 2 11/24- 9:00 a.m.- pain level 6 11/24- 1:00 p.m.- pain level 0 11/24- 5:00 p.m.- pain level 2 11/24- 9:00 p.m.- pain level 3 11/25- 1:00 a.m.- pain level 5 11/25- 5:00 a.m.- pain level 5 11/25- 9:00 a.m.- pain level marked NA 11/25- 1:00 p.m.- pain level 0 11/25- 5:00 p.m.- pain level 0 11/25- 9:00 p.m.- pain level 2 11/26- 1:00 a.m.- pain level 4 Morphine sulfate (concentrate) oral solution 20 mg/ml (milligram/milliliter) give 0.5 ml by mouth every 30 minutes as needed for pain/dyspnea contact hospice prior to giving 7th dose in a given day, order date 11/14/23. Given on the following dates: 11/21- 11:59 a.m.- pain level 9, marked as effective 11/21- 7:28 p.m.- pain level 8, marked as effective			

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	11/22- 4:57 p.m.- pain level 8, marked as unknown effectiveness 11/23- 5:59 a.m.- pain level 7, marked as ineffective 11/23- 7:45 a.m.- pain level 10, marked as ineffective No PRN (as needed) medication was signed as given on 11/24, 11/25, 11/26 Progress notes were reviewed and include, but were not limited to: 11/21/23 at 5:57 a.m., " Resident is having difficulty falling and staying asleep, pain medication and Ativan was non-effective. Resident keeps yelling and crying. Resident repositioned, changed, and was made comfortable, all the interventions was non-effective. Currently in bed yelling out " help, help" Notes put in the NP book for resident to get a prescription for a sleeping med." 11/24/23 at 11:36 a.m., " Late entry: " IDT follow up for medication error on 11/23/23. Nurse notified DNS on 11/23 that resident has been receiving the incorrect dosage of pain medication. Family, Hospice, Physician notified of error. E script sent to pharmacy and correct medication was pulled from EDK. All staff inserviced on correct procedure for medication pass including 6 rights and 3 checks for medications prior to admin. Resident is comfortable at this time." On 1/17/24 at 12:44 p.m., hospice indicated they were not sure how many incorrect doses of pain medication were given to Resident B. Resident B was given half concentration of the ordered dose, they had received notification to clarify the order. The correct dose ordered was 20 mg/ml, give 0.5 ml, and Resident B was given 10 mg/ml, the resident had no adverse effects.			

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	On 1/17/24 at 1:39 a.m., the Administrator indicated the DON identified the medication error, typically hospice provides the medications, she believed the DON told her there is a longer acting pain medication, the one Resident B had ordered was for regular, the order was changed to long acting, it was not in the cart and nursing gave what was in the cart. The Administrator indicated it had been discussed in the morning meeting why Resident B's pain medication was not effective and the DON did a chart review and identified the medication error. The Administrator indicated she would try to find the investigation documentation the DON did, the DON no longer was employed by the facility. On 1/18/24 at 8:15 a.m., the Administrator indicated she could not find the investigation documentation the DON did, Resident B had an order change to increase the pain medication on 11/21/23, from 0.25 to 0.5 ml, nursing was giving 0.25 ml instead of 0.5 ml, her best guess was Resident B was given 11 doses of the incorrect dose. The new order was received on 11/2123 around 4:00 p.m., she was not sure if it was a PCC glitch, she believed an agency nurse put the order in. She called pharmacy and they indicated the medication was delivered on 11/23/23, pharmacy had delivered pain medication on 11/14/23 after the resident had admitted, her best guess is the order to increase the dose was put in late, she had spoken with nursing staff who still worked at the facility, they had informed her they were only seeing 0.25 ml order in the computer during that time. On 1/18/24 at 9:41 a.m., the Administrator indicated if a new order is received nursing puts it in PCC (Point Click Care) it automatically goes to			

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	the pharmacy, they deliver it that evening. The Administrator indicated in morning meeting they go through any new orders, the DON verifies they were put in, she was not at the facility on 11/21/23 and could not verify the DON checked the new orders. On 1/18/24 at 10:05 a.m., [name] pharmacy indicated if an ordered medication is a controlled substance an actual hard script needs to be sent to the pharmacy by the provider, the nurse can put the order in PCC, but it is just a chart order. The pharmacy indicated they received the hard script order on 11/23/23 and the medication was delivered that day. On 1/18/24 at 10:40 a.m., LPN 1 indicated nursing puts the order in the computer, the DR. has to send it in, nursing calls the pharmacy to make sure the DR. sent the order, any controlled substance requires a hard script. On 1/18/24 at 9:41 a.m., the Administrator provided the current policy on administering medications with a revision date of April 2019. The policy included, but was not limited to, Medications are administered in a safe and timely manner, and as prescribed...The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions...Medications are administered in accordance with prescriber orders, including any required time frame...The individual administering the medication checks the label Three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication... This citation relates to Complaint IN00425661.			

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	3.1-35(g)(1)			