STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/18/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00348990. Complaint IN00348990 - Substantiated. Federal/state deficiencies related to the allegations are cited at F-603 and F-689. Survey dates: March 16, 17, 18, 2021 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 8 Medicaid: 52 Other: 10 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 26, 2021	F 0000	In lieu of post survey revisit, the facility respectfully requests desk review of this plan of correction. Thank you	
F 0603 SS=D Bldg. 00	483.12(a)(1) Free from Involuntary Seclusion §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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

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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review the facility failed to appropriately intervene for a resident who was having behaviors by placing the resident in a bedroom alone and shutting the door for 1 of 3 residents reviewed for accidents (Resident B). Finding include: Review of the record of Resident B on 3/16/21 at 1:25 p.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, obstructive sleep apnea, diabetes type 2, morbid obesity, aphasia, major depressive disorder, cerebrovascular vascular disease, pain in left and right shoulder, insomnia, chronic pain syndrome, heart failure, muscle weakness, repeated falls, age-related physical debility and difficulty walking. The Admission Minimum Data Set (MDS) assessment for Resident B, dated 2/8/21, indicated the resident cognitively intact for daily decision making. The resident required extensive assistance of two people to transfer and the resident does not ambulate. The fall scale assessment for Resident B, dated 2/8/21, indicated the resident was at moderate	F 0603	F603 1. Resident B's door remained open per resident request and signage placed on the wall per resident request to indicate resident preference of her door being open at all times. 2. No other residents noted with specific preference regarding their door being open at all times. No other residents were affected by this deficient practice. 3. RN #5 re-educated on resident preference and proper behavior interventions. Nursing staff re-educated on behavior interventions and resident preferences. Resident preferences will be observed during daily rounds to ensure preferences are followed. 4. DON or designee will QA monitor 5 residents to ensure resident preferences are honored and appropriate behavior interventions are in place weekly x 4 weeks, monthly x 6 months	04/09/2021

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	risk for falling. A progress note for Resident B, dated 3/15/21 at 4:16 p.m., indicated the resident was sitting up at the nursing station in her broda chair. The resident wanted to go to bed. This nurse told Resident B the CNA would be back from lunch soon and when the CNA returned the staff would assist her to bed. The resident was placed in her room and then she began yelling, screaming and cursing. The nurse explained there were other residents, and she could not keep screaming or the nurse would shut her bedroom door. The resident continued to scream "so I pulled the door closed." The nurse walked to the nursing station and called the residents daughter. Resident B "started screaming at the top of her lungs and screaming open the door." The nurse hung up the phone with the resident's daughter and went to the resident's room. The resident was lying face down on the floor screaming. The resident would not let the nurse touch her and would not stop screaming. Three staff rolled the resident onto a Hoyer (mechanical lift) blanket and assisted the resident into the bed. The resident was observed to have a hematoma on the left side of her forehead. The resident was given an ice pack and she threw it. The resident would not allow for her vital signs to be checked and said the nurse was not going to touch her. The nurse then heard the resident screaming on the phone with her daughter. The nurse attempted to get the resident's vitals again and she refused. The resident stated the nurse was the reason she fell on the floor and the reason her and her daughter don't have a relationship any longer. The nurse "explained to her again she has to stop screaming or the door will be shut." The resident indicated if the nurse shut her door again, she would open it. The nurse explained that the			

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	resident could not be harming herself. The progress note was signed by RN 5. During an observation and interview with RN 5 on 3/16/21 at 1:00 p.m., Resident B was sitting in front of the therapy gym in her broda chair. RN 5 attempted to give the resident her medicine and the resident refused and said she was not taking anything from RN 5 and another staff would have to give her medication. Interview with RN 5 indicated she did not know why the resident did not like her and would not take medication. RN 5 indicated she just met Resident B for the first time on 3/15/21. During an observation on 3/16/21 at 2:46 p.m., CNA 2 and QMA 3 provided Resident B incontinent care. The resident had a large blue and purple fading bruise on her right hip, a light blue bruise and hematoma on the left side of her forehead. The resident indicated she got the bruising from crawling out of her broda chair and falling due to the nurse shutting her bedroom door because she was "praising the lord" in a loud voice. During an interview with Resident B on 3/18/21 at 10:50 a.m., the resident indicated she could not stand for her door to be closed and it made her feel closed in. The resident indicated the other day a nurse shut her door because she was worshipping the lord. The resident fell trying to crawl out of her broda chair to open her bedroom door. The resident had a sign on her wall that said keep door open at all times. The resident indicated the sign use to say keep the door open at night, but after that nurse shut her in her room the resident had the staff change it to keep it open at all times.			

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	An interview conducted with the Director of Nursing (DON) on 3/18/21 at 11:50 a.m., indicated RN 5 was not trying to be mean to Resident B when she shut her door. RN 5 was trying to protect the other residents from becoming upset. During an interview with the DON and the Administrator on 3/18/21 at 2:30 p.m., RN 5 would be provided education on appropriate interventions for residents that were having behaviors. The restraint policy provided by the DON on 3/18/21 at 1:50 p.m., indicated "Seclusion, which is defined as the placement of a resident alone in a room, shall not be employed." This Federal Tag relates to Complaint IN00348990. 3.1-27(a)(4)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to investigate the root cause of a fall, failed to implement interventions after a fall and failed to supervise a resident who	F 0689	F689 1. Resident B assessed in house, sent to the Emergency Room for evaluation with no new negative findings. Resident B's care plan	04/09/2021

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	was sliding out of a wheelchair for 1 of 3 residents reviewed for accidents (Resident B). Finding include: Record review of Resident B on 3/16/21 at 1:25 p.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, obstructive sleep apnea, diabetes type 2, morbid obesity, aphasia, major depressive disorder, cerebrovascular vascular disease, pain in left and right shoulder, insomnia, chronic pain syndrome, heart failure, muscle weakness, repeated falls, age-related physical debility and difficulty walking. The Admission Minimum Data Set (MDS) assessment for Resident B, dated 2/8/21, indicated the resident cognitively intact for daily decision making. The resident required extensive assistance of two people to transfer and the resident does not ambulate. The fall scale assessment for Resident B, dated 2/8/21, indicated the resident was at moderate risk for falling. The fall care plan for Resident B, dated 2/8/21, indicated the resident was at risk for falls or fall related injury related to debility, pain, depression, diabetes and blood sugar lowering medication. The interventions were encourage and assist to wear appropriate nonskid footwear (2/8/21), keep call light and frequently used personal items within reach (2/8/21), remind the resident that it is the safest practice for the bed to be kept in its lowest position due to sight deficits, however the resident prefers bed to be in the highest position (2/15/21), resident not to be left in room in broda chair without		updated with resident specific fall interventions 2. No other residents were affected by this deficient practice. 3. RN# 4 re-educated on policy and procedure for Falls Management, including specific to follow up, appropriate interventions and appropriate reporting to Management. Nursing staff re-educated on Falls Management policy and procedure, Behavior interventions and appropriate reporting to Management. 4. DON or designee will QA monitor during Clinical meeting each business day to ensure root cause analysis completed for all falls, resident specific interventions in place and Care plan updated. Fall audit tool to be completed weekly x 4 weeks then monthly x 6 months.	

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	supervision (3/17/21), assist with toileting (2/8/21) and assist with transfers (2/8/21). A progress note for Resident B, dated 3/8/21 at 11:39 a.m., indicated the resident was rescheduled for a test. The facility attempted to transport the resident today, but the resident kept sliding out of the wheelchair. The facility will arrange for her to be transported via ambulance on a cot for her next appointment. There was no documentation of Resident B's fall. The care plan indicated there were no interventions implemented after the resident fell on 3/8/21. During an interview with the van driver/CNA on 3/16/21 at 12:30 p.m., indicated on 3/8/21, herself and PCA 1 (Personal Care Assistant) were transporting Resident B to an appointment in the facility van. The resident began lifting up her bottom and scooting herself down in the wheelchair. The van driver and PCA positioned the resident into an upright position, but the resident continued to scoot herself to the end of the wheelchair. The van driver called the Director of Nursing (DON) and reported the resident could not be transported safely by the facility van. The resident was brought back into the facility and was placed in her room. The van driver then went and reported to the nurse what had happened, and that the resident was unable to be transported safely. During an interview with PCA 1 on 3/16/21 at 12:45 p.m., indicated on 3/8/21 herself and the facilities van driver were taking Resident B to an appointment. The resident continuously kept scooting her bottom to the end of the wheelchair. They attempted to reposition her up a few times,			

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	but the resident kept trying to slide out of the wheelchair. The resident was brought back into the facility and placed in her room and the van driver went to tell the nurse what happened. PCA 1 then heard the resident screaming and when she went to the resident's room the resident was laying on the floor. The resident was yelling incoherently and saying leave me alone and get me off the floor. PCA 1, two CNA's and the nurse lifted the resident off the floor using a Hoyer pad (pad to a mechanical lift) and placed her in bed. During an observation on 3/16/21 at 2:00 p.m., Resident B was sitting outside of the therapy gym in a broda chair. The resident was positioned well. During an observation on 3/16/21 at 2:46 p.m., CNA 2 and QMA 3 provided Resident B incontinent care. The resident had a large blue and purple fading bruise on right hip and a light blue bruise and hematoma on her left forehead. During an interview (via phone) with RN 4 on 3/17/21 at 11:36 a.m., indicated she was Resident B's nurse on 3/8/21. RN 4 indicated the resident had an appointment and was being transported by the facility van. The nurse received a phone call from the van driver saying they were bringing Resident B back to the facility because she was not sitting in the wheelchair well and she was not safe to transport. RN 4 indicated she was providing care to another resident and the van driver popped her head in the resident's room and said Resident B was back and was in her room. RN 4 was coming out of the room and a CNA (name unknown) said he found Resident B on the floor. RN 4 and CNA 5 went down to the resident's room and the resident was			

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	on the floor on her back. The resident was screaming at the top of her lungs. The staff lifted the resident up with a sheet and placed her on the bed. The resident escalated from there screaming we were trying to kill her, and the facility needed to be shut down. The resident began saying she was having chest pains and was given nitro twice. The Nurse Practitioner gave an order for the resident to be sent to the hospital. RN 4 indicated she assessed the resident and there were no bruising or injury. The resident reported she was sore, and RN 4 gave her a pain pill. The resident was sent to the Emergency room and the hospital ran test and there were no findings. During an interview CNA 5 on 3/17/21 at 1:15 p.m., indicated she was working on 3/8/21 when Resident B fell out of her wheelchair. The van driver was taking her to an appointment and had to bring her back to the facility because she kept sliding down in her wheelchair and was unsafe to take her. CNA 5 indicated the resident was found on the floor by another CNA (name unknown). The staff took a Hoyer sling and picked her up and placed her in the bed. During an interview with the DON on 3/17/21 at 2:00 p.m., indicated she was unaware of Resident B's fall out of the wheelchair on 3/8/21 when the staff brought her back to the facility after attempting to transport her to an appointment. During an interview with Resident B on 3/18/21 at 10:50 a.m., indicated on 3/8/21 she had an appointment and the facility attempted to transport her in a wheelchair in the facility van. The resident indicated she kept sliding down in the wheelchair and the staff had tried to position her upright a couple times, but she continued to slide down in her wheelchair, so they brought her			

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	back into the facility. The resident indicated the van driver brought her back to her room and she was sitting in the wheelchair right inside her bedroom. The resident started sliding out of her wheelchair and she began screaming "help me I am sliding" but no one came. The resident indicated her bottom went to the end of the wheelchair and the wheelchair flipped over on top of her. The resident indicated she landed on her back. During an interview with the DON on 3/18/21 at 11:50 a.m., indicated Resident B's fall out of the wheelchair on 3/8/21 should have been documented, a physical assessment should have been documented, the fall should have been investigated and interventions should have been implemented. The fall management policy provided by the DON on 3/17/21 at 1:00 p.m., indicated it was the facility policy to ensure residents residing within the facility maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to falls. The procedure included, but were not limited to, any resident experiencing a fall would be assessed immediately by the charge nurse for possible injuries, a neurological assessment would be initiated on all unwitnessed falls, the information would be documented into risk management, all falls would be discussed by the interdisciplinary team to determine the root cause and other possible interventions to prevent further falls. This Federal Tag relates to Complaint IN00348990. 3.1-45(a)(1)			

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	3.1-45(a)(2)			