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	05/24/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435184, IN00434936, IN00435056, IN00434946, IN00434861, IN00434805, IN00434793, IN00434801, IN00434811, IN00434481 and IN00434106. Complaint IN00435184 - No deficiencies related to the allegations are cited. Complaint IN00434936 - Federal/State deficiencies related to the allegations are cited at F-689. Complaint IN00435056- Federal/State deficiencies related to the allegations are cited at f-656 & F-695. Complaint IN00434946 - No deficiencies related to the allegations are cited. Complaint IN00434861 - Federal/State deficiencies related to the allegations are cited at F-689. Complaint IN00434805 - No deficiencies related to the allegations are cited. Complaint IN00434793 - Federal/State deficiencies related to the allegations are cited at F-550 & F-691. Complaint IN00434801 - No deficiencies related to the allegations are cited. Complaint IN00434811- No deficiencies related to the allegations are cited. Complaint IN00434481 - No deficiencies related to the allegations are cited.	F 0000	Please accept the following information as our plan of correction. We respectfully request a desk review in lieu of a post survey revisit. We are alleging compliance as of 6/17/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matt Elwell	Executive Director	06/13/2024

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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	Complaint IN00434106 - No deficiencies related to the allegations are cited. Survey dates: May 21, 22, 23, & 24 2024 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 6 Medicaid: 65 Other: 20 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 29, 2024			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of			

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	the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review the facility failed to provide colostomy care in a manner to promote dignity for 1 of 3 residents reviewed for colostomy care (Resident G). Findings include: Review of the clinical record of Resident G on 5/22/24 at 11:55 a.m., indicated the resident's diagnosis included, but was not limited to acute and chronic respiratory failure, dysphagia, colostomy status, and depression.	F 0550	F550 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident G was assessed for his psychosocial well-being by social service on ---. No negative outcomes voiced or observed. Resident G's ostomy supplies were audited to ensure adequate supplies were on hand by	06/17/2024

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	During an interview with Resident G on 5/21/24 at 3:00 p.m. indicated that 3 to 4 days ago, a nurses aide ran out of the correct fitting nursing supplies during the evening shift and placed a regular clear plastic trash bag over his stoma site and it was not changed with a correct fitting colostomy bag until the following morning. The resident indicated that "my dignity was crushed" when they did this and it "made me feel worthless". During an interview with CNA 7 on 5/22/24 at 12:05 p.m., indicated she was working second shift and Resident G did not have a colostomy bag over his stoma. She indicated that she was told that they had ran out of the colostomy bags and had nothing to put on it. CNA 7 indicated that stool was running all over Resident G and she placed a small trash bag over the stoma and taped it. The resident's rights policy provided on 5/24/24 at 10:30 a.m., by the Executive Director (ED) indicated that all care team members recognize the rights of residents at all times and residents assume their responsibilities to enable dignity, respect, and proper delivery of care. This federal tag relates to Complaint IN00434793. 3.1-3(t)		DNS/Designee on 5/25/2024. **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 with ostomies have the potential to be affected. 100% audit of all residents with ostomies was completed by the Nursing Management Team to ensure ostomy supplies were available on 6/6/24. No concerns were identified. CNA 7 is no longer employed at the facility and therefor cannot receive counseling and/or disciplinary action. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** DNS/Designee interviewed and assessed all residents with colostomy bags by 5/30/2024 with no additional concerns of resident dignity violation. DNS/Designee ensured all nursing staff received education regarding Resident Rights and Dignity Policies by 6/10/2024. An Ad Hoc QAPI meeting was held with Executive Director, Medical Director, DNS, and Social Services to review the plan and findings. This action was completed by the Executive Director on 6/7/24. On 6/1/2024, education was initiated and will	

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			continue until all nursing staff have been educated on ensuring the correct ostomy supplies are to be used on each resident with an ostomy. **How the corrective action(s) will be monitored to ensure the deficient practice does not recure, i.e., what quality assurance program will be put into place?** The DNS/Designee will randomly audit 3 residents with ostomy supplies weekly X 3 months, then monthly X 2 months, then quarterly thereafter. Audits will be reviewed by the QAPI committee until such a time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with QAPI. Ad Hoc QAPI meeting was held with the Executive Director, MDS, DNS, Social Services, Medical Director, and Central Supply to review audits, education, results, and findings on 6/7/2024. The next QAPI meeting will be held on 6/20/2024 and audit records will be reviewed to ensure total compliance is met.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review the facility failed to develop a plan of care for a resident who would refuse to wear a pulse oximeter for 1 of 3 residents reviewed for respiratory care (Resident J). The finding include: Review of the clinical record of Resident J on 5/21/24 at 2:45 p.m. indicated the resident's diagnosis included, but was not limited to chronic respiratory failure with hypoxia, dependence on respirator (ventilator) status, and anxiety disorder. The physician Recapulation (recap), dated May 2024, indicated Resident J had order continuous pulse oximeter. During an observation and interview on 5/21/24 at 1:05 p.m., Resident J was lying in bed with no pulse oximeter on or in his room. Resident J indicated he refused to wear his pulse oximeter. During an Interview 5/21/24 at 1:30 p.m. with Respiratory Therapist (RT) 1 indicated that Resident J refused to wear the pulse oximeter. During an interview with the Director of Nursing (DON) 5/22/24 at 12:30 p.m. indicated that it was Social Services responsibility to implement a care plan for Resident J's refusal to wear a pulse oximeter. The care plan policy provided on 5/22/24 at 10:30 a.m. by the Director of Nursing Services (DNS) indicated the facility's Care	F 0656	**F656** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident J no longer resides at the facility. The care plan for resident J was immediately updated to reflect the refusal to wear a pulse oximeter. **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.** Residents who refuse to wear a pulse oximeter have the potential to be affected by the alleged deficient practice. The Respiratory Therapist/Director of Nursing/Designee have completed an audit to identify residents who have orders to wear a pulse oximeter and refuse to ensure a care plan is in place. Any identified concerns were immediately addressed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Regional Nurse Consultant held an in-service with the Director of Nursing, Social Service	06/17/2024

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	Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. This federal tag relates to complaint IN00435056. 3.1-35(a)		Director, MDS, and Unit Manager regarding "The Care Plan Policy" as it relates to comprehensive care planning for residents who refuse to wear a pulse oximeter. **How the corrective action(s) will be monitored to ensure the deficient practice does not recure, i.e., what quality assurance program will be put into place?** The Respiratory Therapist/Director of Nursing/ Designee will audit residents who have orders to wear a pulse oximeter, residents who refuse have a care plan in place and notification to the physician for refusals has been completed and documented as follows: 3 residents per week x 8 weeks, then 2 residents per week x 8 weeks, then 1 resident per week x 8 weeks. This will continue for no less than 6 months. Any identified concerns will be immediately addressed. The Respiratory Therapist/Director of Nursing/Designee will present the results of the audits to the QAPI Committee each month to ensure compliance is met. Any identified concerns will be immediately addressed. This will continue for no less than 6 months.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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	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 interview and record review, the facility failed to ensure an interdisciplinary team review of a post fall event that would include a root cause analysis and implementation of fall interventions for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/24/24 at 10:47 a.m. The diagnoses included, but were not limited to, encephalopathy, anemia, hypertension, repeated falls, psychotic disorder, diabetes mellitus, and anxiety disorder. A fall care plan, initiated on 7/18/22 and revised on 5/17/24, indicated Resident B was at risk for falls related to history of falls, cognitive deficits, dementia, and use of medications. The interventions added most recently was on 3/28/24 for the following: Bed in lowest position while in bed, Provide reacher, & Bright colored tape to call light on bed. A fall report, dated 5/6/24, indicated the following, "" ...CNA [certified nursing aide] yelled for nurse. upon entering dining room resident was lying on the floor, no injuries noted at this time. Resident helped writer and CNA stand up and get back into	F 0689	**F689** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Immediate action(s) taken for resident found to have been affected, resident B is deceased. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. 100% audit of all residents was conducted by the Nurse Management Team to ensure that each resident that had a documented fall in the last 30 days, had root cause analysis and implementation of fall interventions on 6/7/2024 with no further concerns being identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An Ad Hoc QAPI meeting was held with Executive Director, Medical Director, DNS, and Social	06/17/2024

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	wheelchair ...resident states, "I was trying to stand up and look for my cell phone" ....""		Services to review the plan and findings. This action was completed by the Executive Director on 6/7/24. On 6/1/2024, education was initiated and will continue until all nursing staff have been educated on ensuring that all falls have a root cause analysis conducted and implementation of fall interventions are put into place.	
	A fall report, dated 5/10/24, indicated the following, ""writer called into residents room by activity aid. resident lying on floor next to bed and wheelchair ...resident states, "I was trying to get into my wheelchair" ....""		**How the corrective action(s) will be monitored to ensure the deficient practice does not recure, i.e., what quality assurance program will be put into place?** The DNS/Designee will randomly audit 3 falls weekly X 3 months then monthly for 2 month then quarterly thereafter. Audits will be reviewed by the QAPI committee until such a time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with QAPI. Ad Hoc QAPI meeting was held with the Executive Director, MDS, DNS, Social Services, Medical Director, and Central Supply to review audits, education, results, and findings on 6/7/2024. The next QAPI meeting will be held on 6/20/2024 and audit records will be reviewed to ensure total compliance is met.	
	The progress notes did not indicate any interdisciplinary team (IDT) notes that would include a root cause analysis or any new fall interventions to implement after the fall events on 5/6/24 and 5/10/24.			
	An interview conducted with the Director of Nursing (DON), on 5/24/24 at 12:28 p.m., indicated the expectations are to have IDT review the fall event and implement a new fall intervention including the root cause analysis. The DON indicated she was not the active DON when Resident B fell on 5/6/24 and 5/10/24.			
	A policy titled "Fall Management", revised June 2023, was provided by the Executive Director on 5/24/24 at 12:20 p.m. The policy indicated the following, " ...Post Fall ...Information will be entered into Risk Management ...2. The nurse will implement an intervention following the fall ...5. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ...The fall with be reviewed by the team ...IDT note will be written ...The care plan will be reviewed and updated, as necessary ...."			
	This citation relates to Complaints IN00434936 and IN00434861.			

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	3.1-45(a)(2)			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review the facility failed to provide colostomy services with professional standards when reviewing 1 out of 3 residents for colostomy care (Resident G). The findings include: The clinical record for Resident G reviewed on 5/22/24 at 11:55 a.m., indicated the resident's diagnosis included, but was not limited to acute and chronic respiratory failure, dysphagia, colostomy status, and depression. The physician Recapulation (recap), dated for May 2024, indicated colostomy care every shift and as needed and to rinse colostomy bag with water after emptying . During an observation on 5/21/24 at 1:52 p.m. with QMA 4, Resident G had a colostomy bag intact with clear tape reinforced around it. During an interview with Resident G on 5/22/24 at 11:32 a.m. the resident indicated that staff used a small trash bag instead of a colostomy bag to cover his stoma. The resident also indicated that	F 0691	**F691** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident G was identified at the time of observation to have been affected by the deficient practice. DNS/Designee has assessed resident G and he is no longer affected by the deficient practice. **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 with ostomies have the potential to be affected by the deficient practice. DNS/Designee conducted a complete audit of residents with ostomies on 6/6/2024 with no deficient practices noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	06/17/2024

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	he took a picture with his phone of the trash bag over his stoma to provide proof to the facility that the staff had done this. During an interview with CNA 7 on 5/22/24 at 12:05 p.m., indicated she was working second shift and Resident G did not have a colostomy bag over his stoma. She indicated that she was told that they had ran out of the colostomy bags and had nothing to put on it. CNA 7 indicated that stool was running all over Resident G and she placed a small trash bag over the stoma and taped it. CNA 7 indicated that she informed the Executive Director (ED) and nursing staff. During an interview with RN 5 on 5/23/24 at 12:03 p.m., indicated that she kept having to replace the colostomy bags because they were leaking and she informed the Executive Director (ED) and he said for her to notify the Director of Nursing Services (DNS) which she indicated she did. She indicated that the DNS instructed her to use adhesive paste and tape to help keep the colostomy bag intact. She indicated that the facility did not run out of bags, but did run out of the correct fitting ones for Resident G. She indicated that CNA 7 indicated to her that the colostomy bags kept leaking and that they were having to be changed several times through the shift by CNA 7. During an interview with the Executive Director (ED) on 5/22/24 at 2:35 p.m. indicated that the facility never ran out of colostomy supplies. ED indicated that he was informed by nursing staff that the bags were leaking because they ran out of the correct size for Resident G, but they had plenty of supplies. The ED indicated that he was not made aware of being short supplied until days after the trash bag had been placed over Resident		**practice does not recur?** DNS/Designee interviewed and assessed all residents with colostomy bags by 6/6/2024 with no additional concerns of professional standards. DNS/Designee ensured all nursing staff received education regarding ostomy policy by 6/13/2024. An Ad Hoc QAPI meeting was held with Executive Director, Medical Director, DNS, and Social Services to review the plan and findings. This action was completed by the Executive Director on 6/7/24. On 6/1/2024, education was initiated and will continue until all nursing staff have been educated on ensuring the correct ostomy supplies in addition to professional standards are to be used on each resident with an ostomy. **How the corrective action(s) will be monitored to ensure the deficient practice does not recure, i.e., what quality assurance program will be put into place?** The DNS/Designee will randomly audit 3 residents with ostomy supplies weekly X 3 months, then monthly X 2 months, then quarterly thereafter. Audits will be reviewed by the QAPI committee until such a time consistent substantial compliance has been achieved as determined by the committee. Audit results will be	

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	G's stoma. During an interview with the Director of Nursing Services (DNS) on 5/23/24 at 12:14 p.m. indicated that she was not made aware of the "trash bag situation" until the day that the IDOH had entered the building regarding complaints against the facility. Indicated that staff had notified her 5/12/24 about colostomy bags not sticking to resident's skin. She indicated then for them to use stoma adhesive for the time, then ordered better fitting bags. She indicated that she was never notified after that day about supplies or the evening that the trash bag was placed on Resident G's stoma. The colostomy policy provided by the DNS 5/22/24 at 2:00 p.m. indicated that residents who require colostomy services receive care consistent with professional standards of practice....ostomy care will be provided by licensed nurses under the orders of the attending physician. This Federal tag relates to Complaint IN00434793. 3.1-47(a)(3)		shared with QAPI. Ad Hoc QAPI meeting was held with the Executive Director, MDS, DNS, Social Services, Medical Director (pending schedule), and Central Supply to review audits, education, results, and findings on 6/10/2024. The next QAPI meeting will be held on 6/20/2024 and audit records will be reviewed to ensure complete compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

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	Based on observation, interview and record review the facility failed to have pulse oximeter (measures oxygenated hemoglobin in the blood and heart rate) in place as ordered by the physician for ventilator residents, failed to ensure Respiratory Therapist was knowledgeable where to locate respiratory supplies, failed to provide education to the resident on the importance of wearing the pulse oximeter and failed to notify the physician of the resident's refusal to wear the pulse oximeter for 2 of 3 residents reviewed for respiratory care (Resident C and Resident J). Findings include: 1.) Review of the record of Resident C on 5/22/24 at 1:40 p.m., indicated the resident's diagnosis included, but were not limited to, chronic respiratory failure with or without hypoxia or hypercapnia, diabetes, acute embolism with chronic kidney disease, anemia, anxiety, paraplegia, dependence on ventilator and tracheotomy status. The May 2024 Recapitulation for Resident C, indicated the resident was ordered to have an continuous pulse oximeter and may be off during Activities of Daily Living (ADL) and when out of room. During an interview CNA 3 on 5/21/24 at 1:40 p.m., indicated she was caring for Resident C on 5/20/24 and his pulse oximeter machine was not turned on. During an interview with Respiratory Therapist 1 on 5/21/24 at 12:58 p.m., indicated she was caring for Resident C on 5/20/24 and he did not have on his pulse oximeter. During an interview with RT 8 on 5/22/24 at 11:01	F 0695	**F695** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident J was immediately provided education as to the importance of wearing a continuous pulse oximeter per the physician order. Resident J continued to refuse to wear a continuous pulse oximeter despite education. The physician was notified of the resident's refusal to wear the continuous pulse oximeter despite education. Care plan has been reviewed and updated as appropriate completed on 5/30/2024. Resident C is deceased. Respiratory Therapist #8 was immediately educated regarding location of respiratory supplies completed on 5/24/2024. **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.** Current ventilator residents residing at the facility having an order for continuous pulse oximeter have the potential to be affected by the alleged deficient practice. An audit has been completed for all current ventilator residents residing at the facility to ensure orders for continuous pulse	06/17/2024

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	a.m., indicated she had been caring for Resident C during the night shift on 5/20/24 and he did not have on a pulse oximeter on. RT 8 indicated Resident C had been without a pulse oximeter for 1 or 2 days. RT 8 indicated that the facility had run out of pulse oximeter probes. RT 8 indicated the pulse oximeter probes had been delivered, but no one reported it to her that the supplies was there and she did not see the oxygen probes in the respiratory supply room. RT 8 indicated a day shift nurse located the oxygen saturation probes in the supply room on 5/20/24 and applied it on Resident C. During an interview with the Medical Director on 5/22/24 at 1:55 p.m., indicated his expectations were the facility would have a pulse oximeter in place continuously for Resident C. 2.) Review of the clinical record of Resident J on 5/21/24 at 2:45 p.m. indicated the resident's diagnosis included, but was not limited to chronic respiratory failure with hypoxia, dependence on respirator (ventilator) status, and anxiety disorder. The physician Recapulation (recap), dated May 2024, indicated Resident J had order continuous pulse oximeter. The Quarterly Minimum Data Set (MDS) for Resident J, dated 2/23/24, indicated the resident was cognitively intact for daily decision making. During an observation and interview on 5/21/24 at 1:05 p.m., Resident J was lying in bed with no pulse oximeter on or in his room. Resident J indicated he refused to wear his pulse oximeter. During an Interview 5/21/24 at 1:30 p.m. with Respiratory Therapist (RT) 1 indicated that Resident J refused to wear the pulse oximeter.		oximeter are in place and that the actual pulse oximeters are physically in place completed on 6/6/2024. Residents identified to refuse wearing the continuous pulse oximeter were provided education and if refusal continued despite education, those residents were care planned and the physician notified immediately. Any identified concerns were immediately addressed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** DNS/Designee will provide education on pulse oximetry policy related to the physicians order, notification of physician for residents who refuse. Education will include location of respiratory supplies. This was completed by 6/10/2024. **How the corrective action(s) will be monitored to ensure the deficient practice does not recure, i.e., what quality assurance program will be put into place?** The respiratory therapist, DNS or designee will audit ventilator residents to ensure orders for use of continuous pulse oximetry are in place and followed, refusals are documented with education provided, physician notified of refusals and care plan updated to reflect refusals as follows: 3	

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	A pulse oximetry policy provided by Director of Nursing Services (DNS) on 5/22/24 at 10:30 a.m. indicated that the Majestic Care Connersville (MCC) staff will provide [PULSE OXIMETRY] only as ordered by the physician. This Federal tag relates to Compliant IN00435056. 3.1-47(a)(6)		residents per week for 8 weeks, then 2 residents per week for 8 weeks, the 1 resident per week for 8 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. The respiratory therapist, DNS, or designee will present the results of the audits to QAPI committee each month to ensure compliance is met. Any identified concerns will be immediately addressed. This will continue for no less than 6 months.	