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	08/10/2021

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 Complaints IN00357108, IN00357019 and IN00359367. Complaint IN00357019 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F921. Complaint IN00357108 - Substantiated. Federal/state deficiency related to the allegations is cited at F600. Complaint IN00359367 - Substantiated. Federal/state deficiency related to the allegations is cited at F921. Survey dates: August 9 and 10, 2021 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 7 Medicaid: 45 Other: 30 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on August 17, 2021	F 0000		

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

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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation 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, 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 interview and record review, the facility failed to ensure 1 of 5 resident's remained free from verbal abuse by a staff member to where they experienced subsequent fearfulness regarding the use of her call light for staff assistance. (Resident F) Findings include: An Indiana Department of Health (IDOH) incident report sent to IDOH by the facility on 7-15-21 at 9:10 a.m., indicated a family member of Resident F spoke with the Director of Nursing (DON) by phone the same morning regarding CNA 7 "spoke rudely to the resident regarding the number of times that the resident had turned on her call light." It indicated CNA was immediately suspended, pending the outcome of the investigation by the facility." Additional documentation, undated, by the DON indicated the family member clarified CNA 7 had yelled at Resident F and told her "she had her [call] light	F 0600	F600 1. Resident F assessed with no negative findings. CNA #7 is no longer employed by the facility. 2. All interviewable residents will be interviewed by end of business day 8.31.21 and all findings will be addressed accordingly. 3. Staff re-educated on Abuse policy and Procedure 4. DON or designee to QA monitor weekly x 4 weeks, then monthly x 4 months to ensure residents are free from abuse.	08/31/2021

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	on three times and that was too many." The clinical record of Resident F was reviewed on 8-10-21 at 9:40 a.m. Her most recent Minimum Data Set assessment, dated 7-25-21, indicated she is cognitively intact. A progress note entry, dated 7-15-21 at 8:00 a.m. indicated, "spoke with resident regarding care last evening. Resident states that she was upset but is "ok" now. Resident stated that [name of family member] was upset due to a staff member disagreeing with her about the number of time the resident had placed the call light on. Resident informed that she can turn her call light on as many times as she needs to as staff is here to provide care to her...Res also observed for any bruising or other signs of injury. none observed. Res states she didn't touch me, she just yelled at me. Resident denies pain other than foot per usual. Resident laughing with this writer and appears to have no negative psychosocial effects. Social Services to follow up." Additional post-abuse follow-up indicated no negative lasting effects. A "Care Team Member Corrective Action Form," dated 7-15-21, indicated CNA 7 was terminated, effective 7-15-21, related to "CTM [Care Team Member] spoke to a resident in a rude, harsh manner. This made the resident fearful that she cannot push her call light for help." It indicated CNA 7 had one prior written warning on 11-15-20, but did not elaborate as to what the warning regarded. CNA 7's most recent abuse training was documented as occurring on 2-11-21. In an interview on 8-9-21 at 2:30 p.m., with the DON, she indicated CNA 7 "can sound kind of loud and harsh when she speaks at times." She			

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	indicated she and the Administrator "discussed this at the time and we just cannot have any of our staff sounding or being hateful with the residents. So, she was terminated." In an interview on 8-10-21 at 3:50 p.m., with the Administrator, she indicated, "We let her go because we cannot have our staff speaking to our residents like that." On 8-9-21 at 9:57 a.m., the DON provided a copy of a policy entitled, "Abuse Prevention Program," with a revision date of 2-22-18. This policy indicated, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. (Collectively, herein after "abuse"). Our facility is committed to protecting our residents from abuse by anyone, including, but not necessarily limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to our residents, family members, resident representative, legal guardian, surrogates, sponsors, friends, visitors, or any other individual..." This Federal tag relates to Complaint IN00357108. 3.1-27(a) 3.1-27(b)			
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 -			

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	§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 a through investigation of the fall was conducted and documented for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The clinical record of Resident B was reviewed on 8-9-21 at 10:15 a.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbance, diabetes with polyneuropathy, Alzheimer's disease, hallucinations and restlessness and agitation. Her most recent Minimum Data Set (MDS) assessment, dated 6-30-21, indicated she is moderately cognitively impaired, is able to walk about the facility with the supervision of one person without any assistive devices, and has had no falls since her previous MDS assessment, dated 3-30-21. Review of her Fall Risk Assessment, dated 8-14-20 and identified on her Admission Nursing Assessment indicated no previous history of falls. However, her initial care plan and subsequent care plans identified Resident B at risk for falls. A nursing progress note, dated 7-30-21 at 5:16 p.m., indicated Resident B had an unwitnessed fall and was found on the floor in hallway, outside of the resident's room. Upon assessment by the licensed nurse, she was found to be alert, oriented and able to make simple wants and needs known to staff. The assessment revealed a	F 0689	F689 1. DON, MD updated of resident B's fall. Fall risk assessment completed on Res. B. 2. Fall risk assessment audit completed and fall risk assessments completed as indicated. 3. Nursing staff re-educated on Falls policy, documentation and MORSE fall scale completion. 4. DON or designee to QA monitor weekly x 4 weeks then monthly x 4 months to ensure fall risk policy followed and proper notification and documentation completed on all falls.	08/25/2021

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	small, purple bruised area on both knees with mild pain to the area, but no other injuries. A neurological assessment at the time revealed no abnormalities. A later nursing progress note, dated 7-30-21 at 10:16 p.m., indicated Resident B's guardian was notified of the fall from earlier in the evening. The notations failed to indicate if the facility's Director of Nursing (DON), Administrator or the resident's attending physician were notified of the fall. Continued review of the fall indicated the neurological assessments continued as per the facility's protocol through 8-1-21 at 1:45 a.m. Progress notes were documented on 7-30-21 at 5:16 p.m. and at 10:16 p.m., on 7-31-21 at 4:49 p.m., none on 8-1-21, on 8-2-21 at 2:21 a.m. and at 10:55 a.m., none on 8-3-21, on 8-4-21 at 2:01 p.m. A 72 hour follow up period for the fall would end on at 8-2-21 at 5:16 p.m. In an interview on 8-9-21 at 2:10 p.m., with the DON she indicated on 7-30-21, an agency nurse was working on the unit in which Resident B resided. "When there is a fall, they are to put it into the computer as a fall and complete the documentation. That nurse only documented it in the progress notes and has not been back to complete the paperwork." The DON indicated the nurse on duty at the time of Resident B's fall did not notify her of the fall on that Friday evening and she did not learn about the fall until she came into work on Monday morning (8-2-21). In an interview with the DON on 8-10-21 at 10:05 a.m., she indicated fall risk assessments are to be conducted at admission, quarterly and with a fall. In an interview with the DON on 8-10-21 at 11:01 a.m., she indicated she could			

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	not find any fall risk assessments, except the one from Resident B's admission, dated 8-14-20. In an interview with the Assistant Director of Nursing (ADON) on 8-10-21 at 3:15 p.m., she indicated when a resident has a fall, the licensed nurse is to make sure she assesses the resident, takes care of any emergency care needed, notifies the DON and the resident's attending physician of the fall . The nurse is to "open up the Risk Management tool [in the electronic medical record] to document and evaluate the fall and this will or should identify the need for 72 hour follow up after the fall. If neurochecks are needed, those need to be done, also. The IDT [interdisciplinary team] meets Monday through Friday to evaluate any falls or other issues on the next business day after the event. IDT will review the fall, look for the root cause of the fall and update the care plan with appropriate interventions with the hope of preventing a recurrence of the fall. Neurochecks by themselves do not take the place of the 72 hour follow up; they would simply be a part of the follow-up of the fall. On 8-10-21 at 2:35 p.m., the DON provided a copy of a policy entitled, "Falls and Fall Risk, Managing." This document had a revision date of March, 2018. This policy indicated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls..."			

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	This Federal tag relates to Complaint IN00357019. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the bathrooms located in the memory care unit (MCU) areas are clean and sanitary for 6 of 16 resident bathrooms and for 1 of 3 shower room toilets observed in the East building of the facility. Findings include: On 8-9-21 at 11:20 a.m., an observation of the 300 hall MCU bathrooms was conducted with LPN 4. The following observations were made: -shared bathroom for rooms 304/305, the toilet appeared clean, but continues to "run" and has a strong urine odor. -shared bathroom for rooms 314/315 had a dark brown material located to the interior rim of the toilet and a similar dark brown material was located on the toilet seat. The toilet seat had obvious paint missing. -shared bathroom for rooms 302/303 had a urine odor present and a brown material was located to the anterior interior rim of the toilet, as well as to the front portion of the toilet seat. On 8-9-21 at 11:40 a.m., an observation of the	F 0921	F921 1. Identified bathrooms, toilets and shower rooms cleaned. 2. Sanitation audit completed on resident bathrooms and any soiled/unclean areas identified were cleaned. 3. Staff educated on cleaning up soiled areas as necessary when cleaning items are available and/or notify housekeeping for cleaning assistance as needed. 4. Housekeeping Supervisor or designee with QA audit weekly x 4 weeks then monthly x 4 months to ensure resident bathrooms/toilets remain clean and free from debris/excrement.	08/25/2021

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	100 and 200 halls of the MCU bathrooms was conducted with CNA 3. The following observations were made: -shared bathroom for rooms 101/102 had a medium brown colored material smear located on right front and posterior right of the toilet seat. -room 103 had flecks of dark brown material and toilet paper with same material located in the toilet bowl. -room 104 had a medium brown material located on the right front and inside the rim of the toilet bowl and had a dark brown stain located at the water line of the toilet bowl. -the 100 hall shower room had a dark brown material present, located in the bowl, above the water line. -room 105 had a medium sized medium brown piece of bowel movement (excrement), floating in the toilet bowl. -shared bathroom for rooms 106/107 had a dark brown material located under the posterior toilet bowl rim and above the water line. -shared bathroom for rooms 108/109 had a medium brown material under the right front toilet rim. -shared bathroom for rooms 208/209 had a dark brown material located at the top of the toilet front rim of bowl and to left side of toilet seat. -shared bathroom for rooms 212-213 had a dark brown material located to under the anterior and posterior toilet rim and to above the water line. In an interview on 8-9-21 at 11:25 a.m., with LPN 4, she indicated, "I didn't realize the bathrooms were this bad." In an interview on 8-9-21 at 9:37 a.m., with a family member of Resident B, a resident of the East building, she indicated when she checks her			

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	family member's bathroom, there "is poop all over the bathroom." The family member thinks the defecation in Resident B's room is a result of other residents using the bathroom and not cleaning up after themselves. In an interview on 8-10-21 at 9:15 a.m., with the Director of Nursing (DON), she indicated, "The bathrooms on the dementia care units are almost impossible to keep clean. Because it is a dementia care unit, we have residents wander in and out of rooms, both occupied and unoccupied [rooms], and may use the bathrooms or lie down in the beds in the room. We try to keep up on making sure all the bathrooms are clean, but it is an ongoing battle." The DON indicated Resident B is one of the residents who tends to wander the halls on the MCU and frequently will use the toilets in various rooms and will lie down in various beds. She indicated Resident B is not always be able to clean herself properly and there is sometimes stool smears on the toilet. She indicated this resident is independent with ambulation. This Federal tag relates to Complaints IN00357019 and IN359367. 3.1-19(f)			