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	08/24/2023

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		F 0000		

This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00407259, IN00414292, and IN00414446.

This visit was done in conjunction with the Investigation of Complaint IN00415628.

Complaint IN00407259 - Federal/state deficiencies related to the allegations are cited at F584 and F686.

Complaint IN00414292 - No deficiency due to lack of evidence.

Complaint IN00414446 - Federal/state deficiencies related to the allegations are cited at F584

Complaint IN00415628 - Federal/state deficiencies related to the allegation are cited at F689.

Survey dates: August 16, 17, 18, 21, 22, 23, and 24, 2023

Facility number: 000316
Provider number: 155491
AIM number: 100286370

Census Bed Type:
SNF/NF: 93
Total: 93

Census Payor Type:
Medicaid: 70
Other: 23
Total: 93

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandi Paul	RNC	09/14/2023

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.

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	08/24/2023

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
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 29, 2023			
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 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,			

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	08/24/2023

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
	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 observation, interview, and record review, the facility failed to ensure a dignified environment by a staff member observed cursing in a common area near 3 resident rooms. Findings include: An interview conducted with Resident 46, on 8/16/23 at 1:47 p.m., indicated Unit Manager (UM) 6 attempted to take a fan out of her room indicating it wasn't Resident 46's. UM 6 was coming across as rude. An observation conducted of the Ventilator Unit, on 8/18/23 at 10:43 a.m., of UM 6 stating in a loud tone, "getting on my f***ing nerves" at the nurses' station. This comment was able to be heard from the dining room located behind the nurses' station. There were no other residents at the nurses' station but 3 resident rooms were in close proximity to the nurses' station with their doors open. An interview conducted with the Director of Nursing (DON), on 8/23/23 at 3:26 p.m., indicated the comment made by UM 6 was not appropriate. A policy titled "Promoting/Maintaining Resident Dignity", undated, was provided by the DON on 8/23/23 at 3:18 p.m. The policy indicated to treat each resident with respect and dignity as well as	F 0550	DON/Designee assessed the three residents in rooms adjacent to the ventilator unit nurses station with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured UM 6 received 1:1 counseling and disciplinary action regarding customer service demeanor and the Promoting/Maintaining Resident Dignity policy and by 8/18/23. DON/Designee interviewed and assessed residents on the ventilator unit with no additional concerns of resident dignity violation by 9/15/23. DON/Designee educated facility staff regarding customer service demeanor and the Promoting/Maintaining Resident Dignity policy and by 9/15/23. DON/Designee will interview and assess three residents who reside on the ventilator unit weekly x4 to ensure no additional concerns of resident dignity violation, then as determined by the QAA Committee.	09/15/2023

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	08/24/2023

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
	care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 3.1-3(t)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to			

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	08/24/2023

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
	receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to honor Resident 14's advanced directive for 1 of 1 residents reviewed for code status. Findings include: The clinical record for Resident 14 was reviewed on 8/18/2023 at 11:45 a.m. The medical diagnoses respiratory failure and chronic obstructive pulmonary disease. A Quarterly minimum data set assessment, dated for 6/5/2023, indicated that Resident 14 was cognitively intact. During an interview with Resident 14 on 8/17/2023 at 1:29 p.m., she indicated back in April she had went unresponsive and the staff had to give her CPR for 5 minutes before they got her back. She stated she was a do not resuscitate (DNR) at the time and she wishes the staff "had just let her go". An Indiana Physician Order for Scope of Treatment (POST), dated for 10/4/2022, indicated that Resident 14 was a DNR and was signed by both the resident and her care provider.	F 0578	DON/Designee assessed Resident 14 with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured LPN 14 was educated on the Advanced Directives policy including verifying resident code status prior to initiating CPR and to ensure care reflects the resident's wishes as expressed in the Directive by 9/15/23. DON/Designee reviewed any resident who may have coded in the last 30 days to ensure resident code status was verified prior to initiating CPR and that care reflects the resident's wishes as expressed in the Directive by 9/15/23. DON/Designee educated licensed nurses and STNAs on the Advanced Directives policy including verifying resident code status prior to initiating CPR and to ensure care reflects the resident's wishes as expressed in the Directive by 9/15/23.	09/15/2023

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	08/24/2023

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
	A nursing progress note for Resident 14, dated 4/8/2023, indicated " ...writer [LPN 14] had initiated CPR, stop CPR when writer saw DNR orders on res [resident] files ..." During an interview with LPN 14 on 8/21/2023 at 1:35 p.m., she indicated she was taking care of Resident 14 on the morning of 4/8/2023. She had gone into Resident 14's room to check on resident during morning rounds and found her unresponsive and pulseless. LPN 14 immediately started CPR, including compressions and used her smart watch to call 911 and for help from staff. Two CNAs came in to take over CPR and she went to verify Resident 14's code status. When LPN 14 realized Resident 14 was a DNR, she went to the room and instructed the two CNAs to stop CPR. She did a pulse check and Resident 14 had regained a pulse at that time. LPN 14 indicated she did not know any other way to verify code status other than to check the medical record. A policy entitled, "Advanced Directives", was provided by the DON on 8/21/2023 at 3:00 p.m. The policy indicated, " ...If a resident has a valid Advanced Directive, the facility's care will reflect the resident's wishes as expressed in the Directive ..." 3.1-4(f)(7)		DON/Designee will audit any resident who may have coded weekly x4 to ensure verifying resident code status prior to initiating CPR and to ensure care reflects the resident's wishes as expressed in the Directive, then as determined by the QAA Committee.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.			

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	08/24/2023

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
	The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure a homelike environment on the 300-hallway due to strong urine odor present near Resident G's room.	F 0584	DON/Designee assessed Resident G with no observed negative outcomes from deficiency as cited by 9/15/23. Administrator/Designee ensured	09/15/2023

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	08/24/2023

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
	Findings include: Observations were conducted of the 300-hallway to where there was a urine odor present near and around Resident G's room on the following date(s)/time(s): 8/16/23 at 1:15 p.m., 8/16/23 at 2:39 p.m., 8/17/23 at 9:12 a.m., 8/18/23 at 9:29 a.m., 8/18/23 at 10:16 a.m., & 8/18/23 at 11:42 a.m. An interview conducted with Housekeeping Staff 3, on 8/17/23 at 9:33 a.m., indicated she had worked at the facility for about 4 months. The urine odor "comes and goes" but she was unsure where it's coming from. She conducted cleaning to all rooms on the 300-hallway daily. She doesn't have any special instructions to clean Resident G's room regarding frequency. An interview with Licensed Practical Nurse (LPN) 4, on 8/17/23 at 9:35 a.m., indicated there was a urine odor near Resident G's room. Resident G tends to refuse showers and care. An observation was conducted, on 8/18/23 at 11:42 a.m., to where there were 3 staff members in the process of cleaning Resident G's room. One staff person was on the floor and asking for a scraper to clean the floor to Resident G's room. An interview conducted with the Executive Director, on 8/18/23 at 4:00 p.m., indicated they believed the odor was possibly coming from the air conditioning/heat unit in Resident G's room. So, that was replaced, and he could tell a		the odor to Resident G's room was eliminated by replacing HVAC unit, stripping and waxing the floor, replacing the mattress and recliner by 9/15/23. Administrator/Designee rounded facility to ensure no additional strong odors were observed to current resident rooms by 9/15/23. Administrator/Designee educated facility staff on the Quality of Life – Homelike Environment policy including ensuring resident rooms are free from strong odors by 9/15/23. Administrator/Designee will round facility weekly x4 to ensure no additional strong odors are observed to current resident rooms, then as determined by the QAA Committee.	

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	08/24/2023

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
	difference in the smell. An interview conducted with the Director of Nursing (DON), on 8/23/23 at 3:26 p.m., indicated she would notice an odor in Resident G's room if the staff had just conducted care on him but not on a regular basis. A policy titled "Quality of Life - Homelike Environment", revised May 2017, was provided by the DON on 8/23/23 at 3:18 p.m. The policy indicated the following, "...Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible...Policy Interpretation and Implementation...2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include...f. Pleasant, neutral scents...." This Federal tag relates to Complaints IN00407259 and IN00414446. 3.1-19(f)(5)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and			

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	08/24/2023

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
	interaction in the community. Based on observation, interview, and record review, the facility failed to ensure activity interventions were available for use and in use for 3 of 3 residents reviewed for activities. (Resident 8, 32, and 98) Findings include: 1. The clinical record for Resident 8 was reviewed on 8/22/23 at 9:10 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, mood disorder, and pain. An evaluation for activities, dated 8/4/23, indicated past activity interest and hobbies of travel and television (TV)/radio. An activity care plan, 1/25/23, indicated Resident 8 preferred to be involved in group, independent, and self-directed activities. An intervention was listed as "Preferred activities include: listening to music, work like activities, watching tv, being social when he chooses". Observations were conducted of Resident 8 to where there was no TV located in his room nor music playing on 8/18/23 at 11:53 a.m., 8/21/23 at 1:18 p.m., and 8/22/23 at 11:35 a.m. 2. The clinical record for Resident 32 was reviewed on 8/22/23 at 9:15 a.m. The diagnoses included, but were not limited to, dementia, hypertension, hearing loss, and muscle weakness. An annual minimum data set (MDS) assessment, dated 4/7/23, indicated severe cognitive impairment and listed "very important" to listen to music and to be kept up with the news under	F 0679	DON/Designee assessed Resident 8, Resident 32, and Resident 98 with no observed negative outcomes from deficiency as cited by 9/15/23. Activities Director/Designee ensured Resident 8 was provided a television and radio to their room and in use by 9/15/23. Activities Director/Designee ensured Resident 32 was provided a television and radio to their room and in use by 9/15/23. Activities Director/Designee ensured Resident 98 was provided a television and radio to their room and in use by 9/15/23. Activities Director/Designee audited current resident evaluations and care plans for activities to ensure activity interventions were available for use and in use by 9/15/23. Activities Director/Designee educated activities staff on the Activity Programs policy including ensuring that activity interventions are available for use and in use by 9/15/23. Activities Director/Designee will observe three residents weekly x4 to ensure activity interventions are available for use and in use, then as determined by the QAA Committee.	09/15/2023

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	08/24/2023

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
	activity preferences. An evaluation for activities, dated 8/4/23, indicated Resident 32's past activity interest and hobbies of crafts and TV/radio. She liked independent activities and needed cues and/or encouragement to participate in activities due to cognitive impairment. An activity care plan, revised 7/13/23, indicated Resident 32 to be involved in independent self-directed activities. The intervention indicated her preferred activities included: TV, socializing, reading, and table games. Observations were conducted of Resident 32 to where the TV was either not on, had a fuzzy/blurred screen, and/or no music playing on 8/18/23 at 11:56 a.m., 8/21/23 at 1:20 p.m., and 8/22/23 at 11:35 a.m. 3. The clinical record for Resident 98 was reviewed on 8/22/23 at 9:16 a.m. The diagnoses included, but were not limited to, dementia, cognitive communication deficit, and irritability and anger. An admission MDS assessment, dated 6/18/23, indicated moderate cognitive impairment and listed "very important" to listen to music under activity preferences. An evaluation for activities, dated 6/17/23, indicated past activity interests of Bingo, cards, gardening, and TV/Radio. Under current activity participation the comments listed "Watching TV". An activity care plan, revised 7/24/23, listed an intervention as "resident needs encouragement and reassurance to participate in activity".			

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	08/24/2023

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
	Observations were conducted of Resident 98 to where a TV was not located in the room nor had music playing on 8/18/23 at 11:53 a.m., 8/21/23 at 1:18 p.m., and 8/22/23 at 11:35 a.m. An interview conducted with Certified Nursing Assistant (CNA) 5, on 8/22/23 at 11:39 a.m., indicated she thought it was "weird" that Residents 8 and Resident 98 didn't have TVs in their room. Resident 8 and 98 typically stay in their room. Resident 32 typically stays in her room as well but "she might like the TV". An interview conducted with the Director of Nursing (DON), on 8/23/23 at 3:26 p.m., indicated Resident 8 and Resident 98 were previously on another unit and both had televisions previously. The DON told maintenance about getting Resident 8 and Resident 98 a TV. Maintenance was also looking at Resident 32's TV to see if something was wrong with it. A policy titled "Activity Programs", revised 7/2018, was provided by the DON on 8/23/23 at 3:18 p.m. The policy indicated the following, "...Activity programs designed to meet the needs of each resident are available daily...." 3.1-33(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop			

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	08/24/2023

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
	pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure pressure ulcers were assessed upon admission/readmission to the facility, ensure treatments were initiated timely for identified pressure ulcers, follow-up with recommendations from a wound care provider, and ensure ongoing treatment for pressure ulcers for 2 of 6 residents reviewed for pressure ulcers. (Resident H and Resident J) Findings include: 1a. The clinical record for Resident H was reviewed on 8/18/23 at 10:27 a.m. The diagnoses included, but were not limited to, osteomyelitis of vertebra, pressure ulcer of sacral region, diabetes mellitus, chronic pain syndrome, and contracture. An admission minimum data set (MDS) assessment, dated 7/10/23, indicated Resident H was cognitively intact along with a stage 2 pressure ulcer, a stage 4 pressure ulcer, and 3 deep tissue injuries documented as noted upon admission to the facility. An impaired skin integrity care plan, revised 8/22/23, indicated Resident H had a stage 3 pressure ulcer to left ischium, stage 3 pressure ulcer to right ischium, and a stage 4 to coccyx/sacrum. The interventions included, but not limited to, assess and document skin	F 0686	DON/Designee assessed Resident H with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured Resident H had assessments for all skin impairments, that wound care provider recommendations were implemented, and that treatments were completed as ordered by 9/15/23. DON/Designee assessed Resident J with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured Resident J had assessments for all skin impairments, that wound care provider recommendations were implemented, and that treatments were completed as ordered by 9/15/23. DON/Designee audited and observer current residents with wounds to ensure assessments for all skin impairments, that wound care provider recommendations were implemented, and that treatments were completed as ordered by 9/15/23. DON/Designee educated licensed	09/15/2023

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	08/24/2023

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
	condition and wound treatment as ordered. An admission nursing assessment, dated 7/4/23, indicated the following skin conditions: - left trochanter (hip) with wound vac in place as description, - sacrum as a stage 4 with border gauze in place as description, - right gluteal fold with pannus present/open blisters as description, - other as abrasions to bilateral thighs on description, & - other as abrasions to tops of feet bilaterally as description. There was no facility assessment for the identified skin impairments noted upon admission for Resident H. A wound management company note, dated 7/6/23, indicated a detailed assessment of the following areas noted: - left thigh as a rash with skin prep as treatment twice daily and leave open to air, - right thigh as a rash with skin prep as treatment twice daily and leave open to air, - right abdomen as a venous ulcer with skin prep as treatment twice daily and leave open to air, - left medial heel as a deep tissue injury with skin prep as treatment twice daily and leave open to air, & - right great toe as an arterial ulcer with treatment with betadine twice daily and leave open to air. There was no assessment that included the skin impairment to the sacrum, right gluteal fold, and/or left trochanter/hip.		nurses on the Skin Management policy including ensuring pressure ulcers are assesses on admission/readmission to the facility, treatment orders are initiated timely, wound care provider recommendations are followed up on timely, and ongoing treatments for pressure ulcers are implemented timely by 9/15/23. DON/Designee will audit and observe three residents with wounds weekly x4 to ensure assessments for all skin impairments, that wound care provider recommendations were implemented, and that treatments were completed as ordered, then as determined by the QAA Committee.	

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	08/24/2023

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
	1b. The electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) was reviewed for July of 2023. The following treatment orders were noted: - Apply house barrier cream to bilateral buttocks, coccyx, and peri-area every shift with a start date of 7/4/23, - Betadine solution to be applied to right great toe twice daily with a start date of 7/7/23, - Skin prep wipes to be applied to right thigh twice daily with a start date of 7/7/23, - Skin prep wipes to be applied to left medial heel twice daily with a start date of 7/7/23, - Skin prep wipes to be applied to left thigh twice daily with a start date of 7/7/23, - Skin prep wipes to be applied to right abdomen twice daily with a start date of 7/7/23, - Apply wound vac at 150 mmHg (millimeters of mercury) continuous with 3 pieces of black foam to ischial wound, sacrum, and right ischium. Change three times weekly on Monday, Wednesday, and Friday with a start date of 7/8/23 and a discontinue date of 7/13/23, - Calcium alginate silver to apply to coccyx and cover with bordered foam daily with a start date of 7/12/23, & - Apply wound vac at 150 mmHg (millimeters of mercury) continuous with 3 pieces of black foam to ischial wound, sacrum, and right ischium. Change three times weekly on Monday, Wednesday, and Friday with a start date of 7/14/23. There were no physician orders implemented for the treatment of the identified skin impairments noted upon admission, on 7/4/23, until 7/7/23 and 7/8/23.			

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	08/24/2023

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
	1c. An interview conducted with Resident H, on 8/16/23 at 2:14 p.m., indicated his wound vac was not working for a week and the staff did not change the dressing for that time period. They are inconsistent with treating his wounds. The ETAR for July of 2023 indicated the order for the wound vac to the ischial wound, sacrum, and right ischium, dated for 7/8/23, was blank on 7/8/23, 7/10/23, and 7/12/23. A progress note, dated 7/7/23 at 1:58 a.m., indicated Resident H's wound vac was changed per physician orders. The initial order for the wound vac was dated for 7/8/23. 2a. The clinical record for Resident J was reviewed on 8/22/23 at 10:50 a.m. The diagnoses included, but were not limited to, chronic pain, sepsis, osteomyelitis of vertebra, contracture of muscle, and pressure ulcer to right elbow, sacral region, right buttock, left buttock, and left heel. Resident J was admitted to the facility on 6/14/23. An admission nursing assessment, dated 6/14/23, indicated the following skin impairments: - Left heel unstageable pressure ulcer with description and measurements, - Left buttock stage 3 pressure ulcer with description and measurements, - Coccyx stage 3 pressure ulcer with description and measurements, - Right buttock unstageable pressure ulcer with description and measurements, & - Right elbow stage 2 pressure ulcer with description and measurements. A care plan for pressure ulcers, revised 7/17/23, indicated the following, "...Due to resident			

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	08/24/2023

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
	condition, resident is prone to pressure ulcers, and these are considered to be unavoidable...Interventions...Assess and document skin condition...wound treatment as ordered...." A wound assessment, dated 8/1/23, indicated a previous area to Resident J's coccyx reopened as a deep tissue injury on 7/25/23. It was previously classified as a stage 3 pressure ulcer. The treatment was to cleanse with wound cleanser, utilize medical grade honey, and cover with bordered foam daily. A physician order, with a start date of 7/27/23 at 4:00 a.m., for Medihoney gel to coccyx daily. There were no dressings to coccyx for 7/25/23 and 7/26/23. The ETAR for August of 2023 was reviewed and indicated the following holes for the treatment to Resident J's coccyx with medical grade honey: 8/4/23, 8/5/23, 8/9/23, 8/10/23, & 8/11/23. 2b. Resident J was discharged to the hospital from 8/12/23 to 8/16/23. A readmission nursing assessment, dated 8/16/23, indicated the following skin conditions: - right elbow noted but no description or measurements, - left lower leg (rear) with no description or measurements, - right heel with no description or measurements,			

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	08/24/2023

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
	- left shoulder (rear) with no description or measurements, & - other and "right and left buttocks and left ischium, sacrum" noted under the description without measurements. There was no further documentation of descriptions and/or measurements to Resident J's wounds noted on readmission for 8/16/23. 2c. A physician order, dated 8/17/23, was noted for Medihoney gel to Resident J's coccyx daily. The ETAR for August of 2023 noted the following hole(s) for the Medihoney gel to Resident J's coccyx: 8/17/23 & 8/18/23. An interview conducted with the Director of Nursing (DON), on 8/23/23 at 3:26 p.m., indicated by looking at the paperwork it appeared that the wound vac for Resident H was not signed off as ordered. The facility had started moving some wound treatments to night shift. We have a new Unit Manager to ensure completion and overall consistency of things. The nurses need to put their full assessment in the computer. The goal would be for management to follow up the next business day and that would be our wound care nurse. Treatments should be initiated or requested if there was no order for wound care. A policy titled "Skin Management", dated October of 2019, was provided by the DON on 8/23/23 at 3:18 p.m. The policy indicated the following, "...Policy...It is the policy of [name of corporation] to assess each resident to determine the risk of potential skin integrity impairment.			

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	08/24/2023

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
	Residents will have a skin assessment completed upon admission and no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment...PREVENTION...2. A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and no less weekly...4...a) Care plan interventions will be implemented based on resident specific risk factors...PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY...2. Treatment order will be obtained...3. All alterations in skin integrity will be documented in the medical record...a) Residents admitted or readmitted with alterations in skin integrity will be documented on admission evaluation...4. The wound nurse (licensed nurse assigned responsibility for wounds for the building) will be notified of alterations in skin integrity...a) The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day...7. A plan of care will be initiated to include resident specific risk factors with appropriate interventions...." This Federal tag relates to Complaint IN00407259. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			

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	08/24/2023

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
	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure a carrot device was present and the plan of care reflected the utilization of a boot for 1 of 2 residents reviewed for range of motion. (Resident 82) Findings include: The clinical record for Resident 82 was reviewed on 8/22/23 at 1:19 p.m. The diagnoses included, but were not limited to, hypertension, tracheostomy status, muscle wasting and atrophy, and convulsions. A quarterly minimum data set (MDS) assessment, dated 5/24/23, indicated resident 82 was rarely/never understood. He required extensive assistance with 2 staff for bed mobility, total assistance with 2 staff for transfers, toilet use, personal hygiene, bathing, and total assistance with one staff for dressing. There were no impairments noted for Resident 82's upper or lower extremities. A mobility care plan, revised 5/30/23, indicated Resident 82 had impaired mobility related to contractures to left hand. The interventions listed adaptive equipment for the utilization of "carrot"	F 0688	DON/Designee assessed Resident 82 with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured Resident 82's mobility care plan was reviewed, revised, and that interventions were implemented per care plan by 9/15/23. DON/Designee reviewed current residents mobility care plans to ensure that interventions were implemented per care plan by 9/15/23. DON/Designee educated licensed nurses and nurse aides on the Use of Assistive Devices policy including ensuring that interventions were implemented per care plan by 9/15/23. DON/Designee will observe three residents mobility care plans weekly x4 to ensure that interventions are implemented per care plan, then as determined by the QAA Committee.	09/15/2023

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	08/24/2023

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
	for left hand contractures. Observations were conducted to where Resident 82 did not have a carrot in place to left hand: 8/16/23 at 1:17 p.m., 8/16/23 at 2:12 p.m., 8/17/23 at 9:12 a.m., 8/18/23 at 9:28 a.m., & 8/21/23 at 1:33 p.m. During the observation on 8/21/23 at 1:33 p.m., Resident 82 was noted with a boot in place to his left foot that extended to the middle of his shin. There were no care plans or physician orders for the utilization of such boot. An interview conducted with the Director of Nursing (DON), 8/23/23 at 3:26 p.m., indicated on Resident 82's care plan it does reflect the utilization of the carrot to his left hand but didn't see physician orders for a carrot or the boot. According to Resident 82's care plan did not have any clear direction on when or how often to utilize it. A policy titled "Use of Assistive Devices", undated, was provided by the DON on 8/23/23 at 3:18 p.m. The policy indicated the following, "...2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care...3. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement...." 3.1-42(a)(2)			

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	08/24/2023

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 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 interview, observation, and record review, the facility failed to implement the fall interventions for Resident K for 1 of 3 residents reviewed for falls. Findings include: The clinical record for Resident K was reviewed on 8/22/2023 at 3:35 p.m. The medical diagnoses included bipolar disorder and acquired absence of the left and right leg. A Quarterly minimum data set assessment, dated for 6/20/2023, indicated Resident K was cognitively intact. A fall risk assessment, dated for 11/14/2022, indicated Resident K was a high risk for falls. A nursing progress note, dated for 3/9/2023, indicated Resident K had attempted to self-transfer back to bed, resulting in a fall. An intradisciplinary team note, dated for 3/16/2023, indicated the team reviewed Resident K's fall from 3/9/2023 and would implement an intervention of assisting Resident K back to bed	F 0689	DON/Designee assessed Resident K with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured Resident K had care plan reviewed, revised, and their Kardex updated to ensure communication of preventative fall interventions with the care team by 9/15/23. DON/Designee reviewed residents who fell within the last 30 days to ensure fall interventions were implemented following the fall, care plan was reviewed, revised, and their Kardex was updated to ensure communication of preventative fall interventions with the care team by 9/15/23. DON/Designee re-educated licensed nurses and nurse aides on the Fall Management policy including to ensure fall interventions are implemented following a fall, care plans are reviewed, revised, and Kardex is updated to ensure communication of preventative fall interventions	09/15/2023

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	08/24/2023

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
	after smoke breaks. During an interview with Resident K on 8/21/2023 at 1:29 p.m., she indicated staff does not as offer to assist her back to bed after smoking. During an interview with CNA 8 on 8/22/2023 at 1:45 p.m., she indicated she was not aware to offer to assist Resident K back to bed after smoking. During an observation and interview on 8/22/2023 at 2:40 p.m., Resident K indicated she transferred herself back to be via slide board and staff does not offer to assist her back to bed. During an interview with the DON on 8/22/2023 at 2:52 p.m., she verified that the care plan had not been updated to reflect Resident K's intervention after the 3/9/2023. A policy entitled, "Fall Management", was provided by the DON on 8/22/2023 at 10:30 a.m. The policy indicated, " ...The resident specific care requirements will be communicated to the assigned care team members utilizing the Kardex ...The nurse will implement an intervention following the fall ...The care plan will be reviewed and updated, as necessary ..." This Federal tag relates to Complaint IN00415628. 3.1-45(a)(2)		with the care team by 9/15/23. DON/Designee will audit three residents who fell weekly x4 to ensure fall interventions are implemented following a fall, care plans are reviewed, revised, and Kardex is updated to ensure communication of preventative fall interventions with the care team, then as determined by the QAA Committee.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	08/24/2023

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
	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record record review the facility failed to reweigh a resident after a significant weight loss, notify the family and physician of a significant weight loss and Interdisciplinary Team (IDT) failed to follow a resident with a significant weight loss in the risk nutrition meeting for 1 of 7 residents reviewed for nutrition (Resident 80). Finding include: During an interview and observation with Resident 80 on 8/17/23 at 10:25 a.m., indicated his teeth hurt and bother him all the time. The resident indicated it caused him problems with eating. The resident indicated he was unsure what his normal weight was. The resident was thin in appearance. Review of the record of Resident 80 on 8/22/23 at 11:00 a.m., indicated the resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, chronic	F 0692	DON/Designee assessed Resident 80 with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured Resident 80 was weighed, family and physician were notified of previous weight loss, and that the interdisciplinary team (IDT) followed the weight loss per policy in the nutrition risk meeting per policy by 9/15/23. DON/Designee audited residents with significant weight loss in the last 30 days to ensure weights, re-weights, family and physician notification, and IDT following in nutrition risk meeting per policy by 9/15/23. DON/Designee educated IDT on the Weight Monitoring policy including ensuring that weights,	09/15/2023

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	08/24/2023

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
	obstructive pulmonary disease, hypertension, unsteadiness on feet, altered mental status and major depressive disorder. The plan of care for Resident 80, dated 6/14/23, indicated the resident presented with a potential for nutritional risk related to dementia, heart disease, Chronic Obstructive Pulmonary Disease, congestive heart failure with diuretic use and chronic duodenal ulcer. The interventions included, but were not limited to, notify the physician of significant weight changes. The Quarterly Minimum Data Set (MDS) assessment for Resident 80, dated 6/15/23, indicated the resident was moderately impaired for daily decision making. The resident required supervision of one person for eating. The resident weight on 4/11/23 was 163 pounds, the resident's weight on 5/2/23 was 150 pounds. This indicated a 7.98 % weight loss in less then 30 days. The Registered Dietician progress note for Resident 80, dated 5/19/23 at 1:54 p.m., indicated the resident had a 9.6 % weight loss in 30 days. The resident's weight fluctuates 150-156 pounds. Weight loss is within usual body weight fluctuation. There were no new recommendations. This indicated the facility did not address the resident's weight loss for 17 days after the resident had a significant weight loss. During an interview with the Director Of Nursing (DON) on 8/23/23 at 2:45 p.m., indicated the floor staff or management was responsible to complete a re weight for Resident 80 after he experienced a significant weight loss May 2023. The nursing staff was responsible to notify the physician and		re-weights, family and physician notification, and IDT following in nutrition risk meeting occur per policy by 9/15/23. DON/Designee will audit three residents with significant weight loss weekly x 4 to ensure weights, re-weights, family and physician notification, and IDT following in nutrition risk meeting per policy, then as determined by the QAA Committee.	

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	08/24/2023

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
	the resident's family of the May 2023 weight loss and the DON or Assistant Director Of Nursing (ADON) should have brought it to the attention of the IDT for the resident to be followed in the "risk management meeting". The resident weight monitoring policy provided by the DON on 8/23/23 at 11:30 a.m., indicated a significant weight change was defined as 5% in 30 days. The resident's physician and family would be notified of any verified significant weight change. Residents with verified significant weight change would be followed by the IDT in the risk nutrition meeting. A verified re-weight would be indicated and documented. 3.1-46(a)(1)			
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. Based on observation, interview and record review the facility failed to follow the physician order for oxygen therapy and oxygen saturation levels for 1 of 1 resident reviewed for respiratory therapy (Resident 44).	F 0695	DON/Designee assessed Resident 44 with no observed negative outcomes from deficiency as cited by 9/15/23. DON/Designee ensured Resident 44 had oxygen administered as ordered by 8/24/23. DON/Designee audited current	09/15/2023

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	08/24/2023

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
	Finding include: During an observation on 9/17/23 at 10:06 a.m., Resident 44 was laying in bed with oxygen on via nasal cannula, the oxygen was set at 1.5 liters. During an observation on 9/18/23 at 1:49 p.m.., Resident 44 was laying in bed with oxygen on via nasal cannula, the oxygen was set at 1.5 liters. Review of the record of Resident 44 on 8/22/23 at 1:00 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, anemia, atrial fibrillation, sleep disorder and hypertension. The plan of care for Resident 44, dated 4/18/23, indicated the resident had impaired cardiac output related to hypertension, bundle branch block, aneurysm of the neck artery, atrial fibrillation and anemia. The interventions included, but were not limited to, oxygen as ordered. The progress note for Resident 44, dated 7/13/23 at 10:26 a.m., indicated the Nurse Practitioner was in this morning and a new order was obtained to increase oxygen to 2 liters. The physician order dated 7/13/23 indicated the resident was to have oxygen at 2 liters per minute continuously via nasal cannula every shift for shortness of breath and oxygen saturation less than 95%. Evaluate the resident's heart rate, respiratory rate, pulse oximetry, skin color and breath sounds. The Annual Minimum Data Set (MDS) assessment for Resident 44, dated 8/2/23, indicated the resident was moderately impaired for		residents with oxygen orders to ensure oxygen and oxygen saturation orders were implemented as ordered by 9/15/23. DON/Designee educated licensed nurses on the Oxygen policy including ensuring that oxygen and oxygen saturation orders are implemented as ordered by 9/14/23. DON/Designee will audit three residents with oxygen orders weekly x4 orders to ensure oxygen and oxygen saturation orders are implemented as ordered, then as determined by the QAA Committee.	

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	08/24/2023

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
	daily decision making. The resident did not ambulate and required extensive assistance of two for transfers. During an interview with the Director Of Nursing (DON) on 8/22/23 at 3:15 p.m., indicated the nurse was responsible to ensure Resident 44's oxygen was implemented as ordered. During an interview with the Regional Nurse Consultant on 8/24/23 at 11:25 a.m., the facility did not obtain oxygen saturation every shift. The order did not get correctly put on the Medication Record Administration (MAR) and was unsure what happened. The oxygen policy provided by DON on 8/24/23 at 9:40 p.m., indicated the facility should verify that there was a physician order and review the physician orders or facility protocol for oxygen administration. The assessment included, but were not limited to, oxygen saturation if applicable. 3.1-47(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	08/24/2023

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
	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review the facility failed to have chlorine sanitizer in the dishwasher, cleaning bucket and the third compartment sink for 1 of 3 observations. Finding include: During initial tour of the kitchen on 8/16/23 at 10:30 a.m., with the Dietary Manager (DM), the Dietary Aide was washing the breakfast dishes, the DM indicated it was a heat dishwasher. The rinse was 120 degrees the wash was 150 degrees, the chlorine sanitizer would not register. The DM attempted multiple times up to five attempts to get the chlorine sanitizer to register and did not. The DM indicated the sanitizer was suppose to be at 50 Part Per Million (PPM). The eco lab chlorine test strips expiration date 12/1/2024 would not register for the cleaning bucket or when coming straight out of sanitizer hose in the three compartment sink. The DM called eco lab and they advised to call another local long term care facility and request some test strips from them. During an interview with the District Dietary Manager on 8/16/23 at 2:37 p.m., indicated there was air in the lines and the facility had to prime the lines to get the sanitizer to flow out. The staff	F 0812	No resident experienced a negative outcome from deficiency as cited. Dietary Manager/Designee ensured the correct chlorine sanitizer to the dishwasher, cleaning bucket, and third compartment sink by 9/15/23. Dietary Manager/Designee educated dietary staff on the ecolab manufacturer guidelines including ensuring the dishwasher sanitizer be at a minimum chlorine of 50 PPM, and priming the lines when buckets are changed out by 9/15/23. Dietary Manager/Designee will audit dishwasher, cleaning bucket, and third compartment sink five times weekly x4 to ensure the correct chlorine sanitizer to the dishwasher, cleaning bucket, and third compartment sink, the as determined by the QAA Committee.	09/15/2023

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	08/24/2023

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
	were educated to prime the line when buckets are changed out but need to be retrained. There was nothing wrong with the test strips. The dishwasher, cleaning bucket and sanitizer in the three compartment sink all registered appropriately for sanitizer at this time. The ecolab manufacturer guidelines provided by the Administrator on 8/22/23 at 2:30 p.m., indicated dishwasher was to be at a minimum chlorine required was 50 PPM. 3.1-2(i)3			
F 9999 Bldg. 00	Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) did not work with an expired certification for 1 of 24 CNA certifications reviewed. (CNA 15) Findings include: A licensure binder was reviewed on 8/23/23 at 4:30 p.m. It was noted that CNA 15's certification expired on 7/27/23. An interview with the Human Resource Manager (HRM), on 8/23/23 at 5:45 p.m., indicated that CNA 15 worked full-time. The employee timesheet for CNA 15 indicated she had worked 19 days since their certification expired on 7/27/23. An interview with the Director of Nursing (DON), on 8/23/23 at 5:47 p.m., indicated the HRM was responsible for ensuring the licensure book was	F 9999	No resident experienced a negative outcome from deficiency as cited. Human Resources Coordinator/Designee ensured all staff members have current/active license by 9/15/23. Human Resources Manager/Designee educated all staff on the importance of keeping an active license, and the repercussions of not doing so by 09/15/2023. Human Resources Manager/Designee will audit 2 professional licenses at the facility for current status five times weekly x4 to ensure all licenses are current and active, then as determined by QAA Committee.	09/15/2023

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	08/24/2023

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
	kept up to date with licenses and certifications.			