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	12/09/2021

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

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00368633. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00368633- Substantiated. Federal/State deficiencies related to the allegations are cited at F0761 and F0880. Survey date: December 9, 2021 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 16 Medicaid: 56 Other: 27 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 15, 2021	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **The provider alleges compliance as of 12-29-2021** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when			

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

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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	applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store a resident's Scheduled III medication under double lock in 1 of 1 medication rooms observed (Resident H). Findings include: The clinical record for Resident H was reviewed on 12/9/21 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia with behavioral disturbance. A physician's order, dated 11/10/21, indicated she was to receive Marinol (scheduled III appetite stimulant) 10 mg (milligram) capsule twice daily. On 12/9/21 at 1:45 p.m., the medication room for the Memory Care Unit was observed with LPN 2.	F 0761	**F 761: Label/Store Drugs and Biologicals** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) H was identified during the time of observation. All Nurses have been educated on Medication storage, Medication Administration and locking controls for all narcotics. 2. 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.	12/29/2021

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	She entered the locked medication room. She opened the unlocked and unsecured refrigerator within the locked medication room, which contained a bottle of Marinol. She indicated it was the only "narcotic" medication present in the medication room. The bottle had a fill date of 11/28/21 and had 7 pills in the bottle. She was unaware of the need to have the scheduled III medication double locked. On 12/9/21 at 3:37 p.m., the Regional Infection Prevention Consultant provided the Storage of Controlled Substances policy, revised 8/2020, which read "...Policy Medications classified by the Drug Enforcement Administration as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility...2. Scheduled II through V medications and other medications subject to abuse or diversion are stored in either a permanently affixed, double locked compartment separate from all other medication...3. Controlled substances that require refrigeration are stored within a locked box within the refrigerator..." This Federal tag relates to complaint IN00368633. 3.1-25(n)		1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all Medication rooms and medications were adequately stored under a double lock. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure medications are stored securely. The plan will be revised, as warranted. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at	

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			the QA meeting monthly or until substantial compliance has been determined.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			

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	(ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record	F 0880	**F 880: Infection prevention and control (DPOC)**	12/29/2021

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	review, the facility failed to properly prevent and/or contain COVID-19 by assuring staff wore appropriate personal protective equipment when entering the room of a resident on droplet plus transmission-based precautions for 1 of 3 residents reviewed for transmission-based precautions (Resident B). Findings include: The clinical record for Resident B was reviewed on 12/9/21 at 12:20 p.m. The Resident's diagnosis included, but were not limited to, dementia and Hodgkin lymphoma. On 12/9/21 at 12:25 p.m., her room was observed. A signs were present on the room door and on the wall by the door, which indicated she was in contact droplet transmission-based precautions and that the required PPE (Personal Protective Equipment to enter the room was a N95 mask, universal eye protection, gowns, and gloves. A cart was located outside of the door and contained the needed PPE for entering the room. The MDSC was observed entering the room, wearing goggles and a N95 mask. She did not perform hand hygiene and don a gown or gloves prior to entering. During an interview on 12/9/21 at 12:27 p.m., the MDSC indicated that goggles and the N95 were all that was required to enter the room. On 12/9/21 at 12:28 p.m., CNA (Certified Nursing Assistant) 3 was observed entering the room with a food tray. He was wearing a surgical mask and a face shield. He did not perform hand hygiene, don a N95, gown, or gloves prior to entering the room.		1. Immediate 1. Resident(s) B were identified in this practice. All Residents have the potential to be effected by this practice. 2. All staff members were educated on proper infection control practices, including handwashing and infection control protocol related to the requirements and guidance set forth specific to donning and doffing of PPE. 2. Systemic 1. All residents have the potential to be affected by the alleged deficient practice. 2. LTC infection control self-assessment reviewed by QA team including Medical Director, Infection Preventionist Consultant, DHS, ED and Campus Infection Preventionist. 3. DHS/designee will complete daily audits and rounding to ensure all staff are following protocol and guideline. Audits will be conducted five times weekly X 4 weeks, then twice weekly X 4 weeks, then weekly X 4 weeks, then monthly ongoing. 3. Training	

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	During an interview on 12/9/21 at 12:29 p.m., CNA 3 indicated he had not noticed the sign on the door and should have donned the proper PPE before entering the room. During an interview on 12/9/21 at 12:32 p.m., the Director of Nursing indicated that staff should don the PPE listed on the posted signs prior to entering a transmission-based precaution room. On 12/9/21 at 3:38 p.m., the Regional Infection Prevention Consultant provided the Isolation-Notice of Transmission-Based Precautions policy, revised 8/2019, which read "...Notices will be used to alert personnel and visitors of transmission-based precautions, while protecting the privacy of the resident. Policy Interpretation and Implementation 1. When transmission-based precautions are implemented, the Infection Preventionist (or designee) determines the appropriate notification to be placed on the room entrance door..." This Federal tag relates to complaint IN00368633. 3.1-18(b)		1. DHS/designee will conduct an in-service for all staff on infection control practices and protocol including handwashing and infection control protocol related to the requirements and guidance set forth specific to donning and doffing of PPE. 4. Monitoring 1. DHS/designee will complete daily rounding to ensure proper storage, hand hygiene protocol and infection control procedures are communicated effectively, staff have complete understanding of infection control practices including a complete return demonstration with staff as needed and ensure through visual rounding that staff are complying with all infection control measures to encompass all shifts times 6 weeks and until compliance is maintained. 2. DHS/designee will be responsible for the completion of Infection Prevention QA tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be	

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			developed.	