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	11/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00366494, IN00365901 and IN00365828. Complaint IN00366494- Unsubstantiated due to lack of evidence. Complaint IN00365901- Substantiated. Federal/State deficiency related to the allegations are cited at F-684. Complaint IN00365828- Substantiated. Federal/State deficiencies related to the allegations are cited at F-693 & F-825. Survey dates: November 10, 12, 15 & 16 2021 Facility number: 000316 Provider number: 155491 AIM number: 100286379 Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type: Medicare: 13 Medicaid: 54 Other: 30 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 22, 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 11-18-2021** **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.**	

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

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to complete an abdominal assessment and provide treatment for a resident who had not had a bowel movement for 4 days for 1 of 3 residents reviewed for bowel management (Resident C). Finding include: Review of the record of Resident C on 11/12/21 at 2:05 p.m., indicated the resident's diagnoses included, but were not limited to, chronic pain, muscle weakness and constipation. The Quarterly Minimum Data Set (MDS) assessment, dated 9/24/21, indicated the resident required extensive assistance of two people for bed mobility and toileting. The resident was always incontinent of their bowels. The plan of care indicated the resident was at risk for constipation due to decreased mobility and had a long history of hemorrhoids. The interventions included, but were not limited to, administer bowel plan as ordered, administer medications as ordered, assess abdomen and bowels sounds if there was no bowel movement for three days and document abnormal findings	F 0684	**F 684: Quality of Care** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) C was identified during the time of observation. All residents have been reviewed per bowel and bladder protocol policy. All nurses have been educated on bowel protocol and assessment. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all Residents had a BM within the guidelines of the bowel and bladder protocol.	11/18/2021

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	and notify the physician. The bowel movement report dated, October 2021, indicated the resident did not have a bowel movement on 10/9/21, 10/10/21, 10/11/21 and 10/12/21. The physician order for Resident C, dated October 2021, indicated the resident was ordered milk of magnesia 30 milliliters (ml) as needed for constipation if the resident did not have a bowel movement in three days. Dulcolax 10 milligrams (mg) 1 suppository rectally every 24 hours at bedtime as needed for constipation if no result from milk of magnesia. Fleet oil enema insert 1 dose rectally as needed for constipation if no results from dulcolax. The Medication Administration Record (MAR), dated October 2021, indicated the resident did not receive any of the medication ordered on 10/9/21, 10/10/21, 10/11/21 or 10/12/21 when the resident was unable to have a bowel movement. During an interview with the Director Of Nursing on 11/16/21 at 1:35 p.m., verified Resident C did not have an bowel assessment completed or medication administered when she did not have a bowel movement on 10/9/21, 10/10/21, 10/11/21 and 10/12/21. The DON indicated the floor nurse caring for the resident was responsible to complete the assessment and administer the medication. The facilities expectation was the medication would be administered as ordered by the physician. During an interview with the DON on 11/16/21 at 2:10 p.m., indicated the facility did not have a bowel management policy. The facility would expect an bowel assessment would be completed for a resident who had not had bowel movement		BM report reviewed daily as needed. 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 X 4 weeks, then daily 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 the QA meeting monthly or until substantial compliance has been determined.	

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	for 3 days. This Federal tag relates to Complaint IN00365901. 3.1-37			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on interview and record review, the facility failed to provide enteral feedings as ordered by the physician for 1 of 3 residents reviewed for enteral feedings (Resident B). Findings include:	F 0693	**F 693: Tube Feeding Mgmt/Restore Feeding Skills** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) B was	11/18/2021

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	The clinical record for Resident B was reviewed on 11/15/2021 at 11:15 a.m., the diagnoses include, but were not limited to, dysphagia oropharyngeal phase, dependence on respirator, tracheostomy status, and gastrostomy status. An Admission Minimum Data Set, dated 10/21/2021, indicated Resident B needed extensive assistance with eating and was receiving tube feedings (enteral feedings). A physician order, dated 10/15/2021, indicated Resident B was to receive 75 mL (milliliters) of Vital 1.2 (type of enteral feeding) every hours continuously. No acknowledgement of Resident B receiving tube feeding was found on the medication administration records for October and November 2021. A care plan, dated 10/15/2021, indicated Resident B relied solely on licensed nurse for hydration/nutrition via gastronomy tube, needed to have intake documented, and indicated staff to administer tube feedings as per physician order. A confidential interview indicated Resident B did not receive tube feeding while he was at the facility. The interviewee indicated that there was, "no pole, pump, nothing" in Resident B's room and Resident B reported to them multiple times that he was not receiving his tube feedings. An interview with Regional Clinical Support (RCS), on 11/15/2021 at 2:31 p.m., indicated that the order for tube feeding for Resident B was put in incorrectly at admission and that there was no documentation for him receiving tube feeding during his stay. Indicated the staff nurse		identified during the time of observation. All Residents requiring tube feeding have been assessed for appropriate treatment and services. All nurses have been educated on Gtube feedings/assessment. 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. 1. All Residents requiring tube feeding have the potential to be affected by this practice. 2. All Residents with physicians orders for enternal tube feeding have been reviewed for order entry, accuracy and completion of documentation. 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 daily for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure medications are stored securely. The plan will be revised, as warranted.	

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	is to verify and document tube feedings per physician order every shift. A policy entitled, "Enteral Feedings", was provided by RCS on 11/15/2021 at 1:30 p.m. The policy indicated, "The Nurse confirms that orders for enteral nutrition are complete." This Federal tag relates to Complaint IN00365828 3.1-44(a)(2)		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 the QA meeting monthly or until substantial compliance has been determined.	
F 0825 SS=D Bldg. 00	483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of			

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	specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Based on interview and record review, the facility failed to provide occupational and speech-language therapy services as ordered by a physician for 1 of 3 residents reviewed for therapy services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/15/2021 at 11:15 a.m. The diagnoses include, but were not limited to, dysphagia oropharyngeal phase, dependence on respirator, tracheostomy status, and gastrostomy status. An Admission Minimum Data Set, dated 10/21/2021, indicated Resident B needed assistance of one staff for transferring, dressing, and bathing. Resident B was receiving physical therapy and respiratory therapy. A physician order, dated 10/15/2021, indicated occupational therapy evaluation and treatment. A physician order, dated 10/15/2021, indicated speech therapy evaluation and treatment. A confidential interview indicated that Resident B did not receive therapy to help him "learn to take care of himself" or assist with his eating/speaking since he was admitted to the facility. Interviewee stated they spoke to DON and Administrator at the facility multiple times prior to Resident B's discharge about him not receiving therapy as ordered, but therapies were never stated.	F 0825	**F 825: Provide/Obtain specialized Rehab Services** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) B was identified during the time of observation. All therapy staff have been educated on evaluation and treatment plans upon physician order. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed on all Residents reviewing physician order and need for therapeutic services. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	11/18/2021

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	No therapy evaluation or documentation was provided for occupational or speech-language therapies. An interview with Therapy Manager, on 11/15/2021 at 3:02 p.m., indicated that Resident B did not receive services of occupational or speech-language therapies while at the facility. An expectation of order to evaluation for therapy services was 1-3 days. A care plan for Resident B, dated 10/15/2021, indicated the issue of impaired communication with the intervention of refer to speech therapy as ordered. A policy entitled, "Scheduling Therapy Services", was provided by the Medical Records on 11/16/2021 at 12:27 p.m. The policy indicated, "Therapy Services shall be scheduled in accordance to the resident's treatment plan." This Federal tag relates to Complaint IN00365828 3.1-23(a)(1)		1. DOR or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then daily 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 the QA meeting monthly or until substantial compliance has been determined.	