STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491  NAME OF PROVIDER OR SUPPLIER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1020 F. STH. STREET			ED			
MAJEST	TIC CARE OF CON	NERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE		
F 0000 Bldg. 00	IN00366494, IN00 Complaint IN0036 lack of evidence.  Complaint IN0036 Federal/State deficallegations are cite Complaint IN0036 Federal/State deficallegations are cite Survey dates: Nove Facility number: 0 Provider number: 1002 Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type Medicare: 13 Medicaid: 54 Other: 30 Total: 97 These deficiencies accordance with 4	5828- Substantiated. iencies related to the d at F-693 & F-825.  ember 10, 12, 15 & 16 2021  00316 155491 286379  e: reflect State Findings cited in	F 0000	The creation and submission this Plan of Correction does not constitute an admission this provider of any conclus set forth in the statement of deficiencies, or any violation regulation.  This provider respectfully requests that State Report For Correction be considered Letter of Credible Allegation. The provider alleges compliance as of 11-18-202.  The facility respectfully requests a desk review for the low scope and severity of this survey in lieu of a post-survey revisit.	by ion n of Plan the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000316

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	TE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMP			COMPL	ETED
		155491			11/16/	2021	
				CTREET	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
MAJESTI	C CARE OF CONN	IERSVILLE			5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	/E	DATE
F 0684	483.25						
SS=D	Quality of Care						
Bldg. 00	§ 483.25 Quality o	of care					
Ü		a fundamental principle that					
	•	ment and care provided to					
	facility residents. E						
	-	ssessment of a resident, the					
	•	e that residents receive					
	•	e in accordance with					
	professional stand	lards of practice, the					
	comprehensive pe	erson-centered care plan,					
	and the residents'	choices.					
	Based on interview	and record review the facility	F 06	584	F 684: Quality of Care		11/18/2021
	failed to complete a	n abdominal assessment and			1. What corrective action(s)	)	
	provide treatment for	or a resident who had not had			will be accomplished for those		
	a bowel movement	for 4 days for 1 of 3 residents			residents found to have been		
	reviewed for bowel	management (Resident C).			affected by the deficient praction	ce.	
					1. Resident(s) C was		
	Finding include:				identified during the time of observation. All residents have	÷	
	Review of the recor	rd of Resident C on 11/12/21			been reviewed per bowel and		
	at 2:05 p.m., indicat	ted the resident's diagnoses			bladder protocol policy. All nur	ses	
		not limited to, chronic pain,			have been educated on bowel		
	muscle weakness ar	nd constipation.			protocol and assessment.		
		mum Data Set (MDS)			How other residents have	/ing	
		/24/21, indicated the resident			the potential to be affected by		
	required extensive a	assistance of two people for			same deficient practice will be		
	•	ileting. The resident was			identified and what corrective		
	always incontinent	of their bowels.			action(s) will be taken.		
	The plan of care ind	licated the resident was at risk			All Residents have the		
	-	to decreased mobility and			potential to be affected by this		
	had a long history o				practice.		
		led, but were not limited to,					
		an as ordered, administer			2. A campus wide review v	vas	
	-	red, assess abdomen and			completed to ensure all Reside		
	bowels sounds if the	ere was no bowel movement			had a BM within the guidelines	of	
	for three days and d	ocument abnormal findings			the bowel and bladder protoco	d.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M6PQ11 Facility ID: 000316

If continuation sheet Page 2 of 8

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTIO		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155491	B. W	NG	·	11/16/	2021
		<u> </u>		CTDEET /	ADDRESS CITY STATE ZID CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
		JEDOVILLE			5TH STREET		
WAJES I	IC CARE OF CONN	NEKOVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and notify the phys	ician.			BM report reviewed daily as		
					needed.		
		ent report dated, October					
		resident did not have a bowel			3. What measures will be	put	
		21, 10/10/21, 10/11/21 and			into place and what systemic		
	10/12/21.				changes will be made to ensu		
					that the deficient practice doe	s	
		r for Resident C, dated			not recur.		
		cated the resident was			4 DUO D : "		
		gnesia 30 milliliters (ml) as			DHS or Designee will		
	_	ition if the resident did not			complete an audit at varied til		
		ment in three days. Dulcolax			on varied shifts five times we	,	
		1 suppository rectally every			X 4 weeks, then daily for 4 weeks, then		
		e as needed for constipation if			then weekly for 4 weeks, ther	1	
		of magnesia. Fleet oil enema			monthly ongoing to ensure	oh.	
		y as needed for constipation ulcolax. The Medication			medications are stored secur The plan will be revised, as	eıy.	
		cord (MAR), dated October			warranted.		
		resident did not receive any			warranteu.		
		rdered on 10/9/21, 10/10/21,			4. How the corrective		
		21 when the resident was			action(s) will be monitored to		
	unable to have a bo				ensure the deficient practice	will	
		Wor movement.			not recur, i.e., what quality	••••	
	During an interview	w with the Director Of Nursing			assurance program will be pu	ıt into	
	_	p.m., verified Resident C did			place.		
		assessment completed or			<u> </u>		
		stered when she did not have a			1. For quality assurance,	the	
		n 10/9/21, 10/10/21,			DHS or designee will review a		
		/21. The DON indicated the			findings daily, with subsequer	-	
	floor nurse caring f				corrective action and education		
		olete the assessment and			for identified staff.		
		ication. The facilities					
	expectation was the	e medication would be			2. Findings will be reporte	ed at	
	administered as ord	lered by the physician.			the QA meeting monthly or ur	ntil	
					substantial compliance has b	een	
	During an interview	with the DON on 11/16/21			determined.		
	at 2:10 p.m., indica	ted the facility did not have a					
	bowel management	policy. The facility would					
	expect an bowel ass	sessment would be completed					
	for a resident who h	nad not had bowel movement					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS. CITY, STATE, ZIP CODE   1029 E 5TH STREET   CONNERSVILLE   CONNERSVILLE, IN 47331	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY  COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF CONNERSVILE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  PREFEX TAG  for 3 days.  This Federal tag relates to Complaint IN00365901.  3.1-37  F 0693  483.25(g)(4)(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy, and enteral fluids). Based on a resident's compensative and enteral feeding was clinically indicated and consented to by 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 prevention, dierrive, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.  F 0693  F 693: Tube Feeding Skills  Introduced in the provide enteral feeding sas on the feeding sas on interview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings as Introview and record review, the facility lailed to provide enteral feedings a				00		
SUMMARY STATEMENT OF DEFICIENCIES   ID PREPRIX (EACH DEFICIENCY MUST BE PRICEIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPRIX TAG   For 3 days.   This Federal tag relates to Complaint IN00365901.   3.1-37     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.   F 0693   F 693: Tube Feeding Mgmt/Restore Feeding Skills   11/18/2021				1029 E	5TH STREET	11/10/2021
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  for 3 days.  This Federal tag relates to Complaint IN00365901.  3.1-37  F 0693 SS=D Bldg. 00  Flower between the facility must ensure that a resident-sedient complements and consended to by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident, and services to restore, if possible, oral eating skills and to prevent complications of enteral freeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal lucers.  Based on interview and record review, the facility failed to provide cniteral feedings as					T	
This Federal tag relates to Complaint IN00365901.  3.1-37  F 0693	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
reviewed for enteral feedings (Resident B).  Findings include:  The state of the physician for 1 of 3 residents are sidents found to have been affected by the deficient practice.  The state of those residents found to have been affected by the deficient practice.  The state of those residents found to have been affected by the deficient practice.	F 0693 SS=D	for 3 days.  This Federal tag relations and assistance of enteral means rectreatment and servoral eating skills a of enteral feeding aspiration pneumodehydration, metanasal-pharyngeal  Based on interview facility failed to proordered by the phys reviewed for enteral metal and servoral eating skills a of enteral means rectreatment and servoral eating skills a of enteral feeding aspiration pneumodehydration, metanasal-pharyngeal	anti/Restore Eating Skills Enteral Nutrition stric and gastrostomy aneous endoscopic percutaneous endoscopic percutaneous endoscopic perteral fluids). Based on a mensive assessment, the methat a resident- resident who has been able me or with assistance is not hods unless the resident's memonstrates that enteral ally indicated and me resident; and resident who is fed by meives the appropriate rices to restore, if possible, muthor to prevent complications including but not limited to main, diarrhea, vomiting, bolic abnormalities, and sulcers.  and record review, the revide enteral feedings as ician for 1 of 3 residents		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 practi	11/18/2021

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M6PQ11

Facility ID: 000316

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
Tanb Thank of Contidents.		155491	B. W	ING		11/16/2021	
				CERCE	A DDDDGG CKEY CEATE THE CODE		
NAME OF F	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
					5TH STREET		
MAJEST	MAJESTIC CARE OF CONNERSVILLE			CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		for Resident B was reviewed			identified during the time of		
		1:15 a.m., the diagnoses			observation. All Residents		
	include, but were n	ot limited to, dysphagia			requiring tube feeding have be	een	
		se, dependence on respirator,			assessed for appropriate		
	tracheostomy status	s, and gastrostomy status.			treatment and services. All nu	rses	
					have been educated on Gtube	Э	
		imum Data Set, dated			feedings/assessment.		
	10/21/2021, indicat	ted Resident B needed					
	extensive assistance	e with eating and was			2. How other residents ha	ving	
	receiving tube feed	ings (enteral feedings).			the potential to be affected by	the	
					same deficient practice will be	;	
	A physician order,	dated 10/15/2021, indicated			identified and what corrective		
	Resident B was to a	receive 75 mL (milliliters) of			action(s) will be taken.		
	Vital 1.2 (type of en	nteral feeding) every hours					
	continuously.				All Residents requiring		
					feeding have the potential to b	oe	
	No acknowledgeme	ent of Resident B receiving			affected by this practice.		
	tube feeding was fo	ound on the medication					
	administration reco	rds for October and			2. All Residents with		
	November 2021.				physicians orders for enternal		
					tube feeding have been review	wed	
	A care plan, dated	10/15/2021, indicated			for order entry, accuracy and		
	Resident B relied so	olely on licensed nurse for			completion of documentation.		
	hydration/nutrition	via gastronomy tube, needed					
	to have intake docu	mented, and indicated staff to			3. What measures will be	put	
	administer tube fee	dings as per physician order.			into place and what systemic		
					changes will be made to ensu		
	A confidential inter	view indicated Resident B did			that the deficient practice doe	s	
	not receive tube fee	eding while he was at the			not recur.		
	facility. The intervi	ewee indicated that there was,					
	"no pole, pump, no	thing" in Resident B's room			DHS or Designee will		
	and Resident B rep	orted to them multiple times			complete an audit at varied tir	nes	
	that he was not rece	eiving his tube feedings.			on varied shifts five times wee	ekly	
					x4 weeks, then daily for 4 wee	eks,	
	An interview with l	Regional Clinical Support			then weekly for 4 weeks, then	l	
	(RCS), on 11/15/20	21 at 2:31 p.m., indicated			monthly ongoing to ensure		
	that the order for tu	be feeding for Resident B			medications are stored secure	ely.	
	was put in incorrect	tly at admission and that there			The plan will be revised, as		
	was no documentat	ion for him receiving tube			warranted.		
		stay. Indicated the staff nurse					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		URVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN		BUILDING 00 COM		COMPLE	OMPLETED		
		155491	B. W	B. WING		11/16/2	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				5TH STREET		
MAJESTIC CARE OF CONNERSVILLE				ERSVILLE, IN 47331			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	iment tube feedings per			<ol><li>How the corrective</li></ol>		
	physician order ever	ry shift.			action(s) will be monitored to		
					ensure the deficient practice w	rill l	
		Enteral Feedings", was			not recur, i.e., what quality		
		n 11/15/2021 at 1:30 p.m. The			assurance program will be put	into	
		he Nurse confirms that orders			place.		
	for enteral nutrition	are complete."					
					1. For quality assurance, the		
	This Federal tag rela	ates to Complaint			DHS or designee will review a	, ,	
	IN00365828				findings daily, with subsequent corrective action and education		
	3.1-44(a)(2)				for identified staff.		
	3.1- <del>44</del> (a)(2)				ior identified staff.		
					Findings will be reported	l at	
					the QA meeting monthly or un		
					substantial compliance has be		
					determined.		
							İ
F 0825	483.65(a)(1)(2)						
SS=D	-	ecialized Rehab Services					
Bldg. 00		ed rehabilitative services.					
	§483.65(a) Provisi						
	•	bilitative services such as					
	but not limited to p						
		pathology, occupational					
	therapy, respirator						
		ces for mental illness and					
		ty or services of a lesser th at §483.120(c), are					
	•	in at §483.120(c), are ident's comprehensive					
	plan of care, the fa						
	plan or care, the la	ionity must-					
	§483.65(a)(1) Prov	vide the required services;					
	or						
	§483.65(a)(2) In a						
		the required services					
	from an outside re	source that is a provider of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M6PQ11 Facility ID: 000316

If continuation sheet Page 6 of 8

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155491	B. W	NG		11/16/	2021
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
MAILOT		IEDOVII I E			5TH STREET		
MAJESTIC CARE OF CONNERSVILLE			COMME	ERSVILLE, IN 47331			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  ID  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX		ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	ilitative services and is not					
		ticipating in any federal or					
		orograms pursuant to					
	section 1128 and	1156 of the Act.					
			F 08	325			11/18/2021
		and record review, the			F 825: Provide/Obtain		
		ovide occupational and			specialized Rehab Services		
		erapy services as ordered by a					
		residents reviewed for			What corrective action(	,	
	therapy services. (R	Resident B)			will be accomplished for those	9	
					residents found to have been		
	Findings include:				affected by the deficient pract	ice.	
	The clinical record for Resident B was reviewed				1. Resident(s) B was		
	on 11/15/2021 at 11	1:15 a.m. The diagnoses			identified during the time of		
		ot limited to, dysphagia			observation. All therapy staff l	nave	
		e, dependence on respirator,			been educated on evaluation		
	tracheostomy status	s, and gastrostomy status.			treatment plans upon physicia	an	
					order.		
	An Admission Min	imum Data Set, dated					
	10/21/2021, indicat	ed Resident B needed			2. How other residents ha	ving	
	assistance of one st	aff for transferring, dressing,			the potential to be affected by	the	
	and bathing. Reside	ent B was receiving physical			same deficient practice will be	;	
	therapy and respirat	tory therapy.			identified and what corrective		
					action(s) will be taken.		
		dated 10/15/2021, indicated					
	occupational therap	y evaluation and treatment.			All Residents have the		
					potential to be affected by this	3	
		dated 10/15/2021, indicated			practice.		
	speech therapy evaluation and treatment.						
					2. A campus wide review	was	
		view indicated that Resident			completed on all Residents		
		erapy to help him "learn to			reviewing physician order and		
	take care of himself				need for therapeutic services.		
		ce he was admitted to the			2 \\\/\begin{array}{c} \\\/\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	nut	
		e stated they spoke to DON			3. What measures will be	ρuι	
		at the facility multiple times			into place and what systemic	ro.	
		s discharge about him not			changes will be made to ensu		
		s ordered, but therapies were			that the deficient practice doe	5	
	never stated.				not recur.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155491 B. WING		11/16/2021	
			CTDEET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		E 5TH STREET	
MAJESTIC CARE OF CONNERSVILLE			ERSVILLE, IN 47331		
		CONN			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
IAU	No therapy evaluation provided for occupation therapies.  An interview with 11/15/2021 at 3:02 B did not receive sees speech-language the An expectation of conservices was 1-3 day at A care plan for Resindicated the issue with the intervention as ordered.  A policy entitled, "was provided by the 11/16/2021 at 12:22" "Therapy Services sees a see a	ion or documentation was ational or speech-language  Therapy Manager, on p.m., indicated that Resident ervices of occupational or erapies while at the facility. order to evaluation for therapy ys.  ident B, dated 10/15/2021, of impaired communication on of refer to speech therapy  Scheduling Therapy Services", e Medical Records on 7 p.m. The policy indicated, shall be scheduled in esident's treatment plan."	IAU	1. DOR or Designee will complete an audit at varied tire on varied shifts five times were x4 weeks, then daily for 4 we then weekly for 4 weeks, then monthly ongoing to ensure medications are stored secure. The plan will be revised, as warranted.  4. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be puplace.  1. For quality assurance, DHS or designee will review a findings daily, with subsequence corrective action and education for identified staff.  2. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined.	mes ekly eks, n rely.  will  ut into  the any nt on  ed at ntil
				the QA meeting monthly or un substantial compliance has b	ntil

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M6PQ11 Facility ID: 000316

If continuation sheet

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