

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 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	<p>This visit was for the Investigation of Complaints IN00403929, IN00405361 and IN00405440.</p> <p>Complaint IN00403929. Federal/state deficiency related to the allegations is cited at F921.</p> <p>Complaint IN00405361. Federal/state deficiencies related to the allegations are cited at F679 and F921.</p> <p>Complaint IN00405440. No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 10, 11 and 12, 2023</p> <p>Facility number: 000316 Provider number: 155491 AIM number: 100286370</p> <p>Census Bed Type: SNF/NF: 96 Total: 96</p> <p>Census Payor Type: Medicare: 3 Medicaid: 74 Other: 19 Total: 96</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on April 13, 2023</p>	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 5-10-2023 to the annual licensure survey completed on 4-12-2022. We respectfully request a paper review and will provide any additional information requested.	
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Mandi Paul	TITLE RNC	(X6) DATE 05/03/2023
---	------------------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>§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 interaction in the community.</p> <p>Based on observation, interview and record review, the facility failed to provide activities programming for the facility's advanced memory care unit (AMCU), which has the capability of affecting all 18 residents of the AMCU.</p> <p>Findings include:</p> <p>On 4-12-23 at 11:30 a.m., Corporate Support Staff provided a copy of the "April 2023 Majestic Gardens 300," or AMCU activities calendar. The scheduled activities for 4-10-23 included, but was not limited to "Coffee/News" at 10:00 a.m., "Exercises" at 10:30 a.m., and "Word Games" at 11:15 a.m. None of these scheduled activities were observed to be provided to the residents of the AMCU.</p> <p>On 4-12-23 at 11:30 a.m., Corporate Support Staff provided a copy of the "April 2023 Majestic Gardens 300," or AMCU activities calendar. The scheduled activities for 4-11-23 included, but was not limited to "Ball Toss" at 1:00 p.m. This activity was not observed to be provided to the residents of the AMCU.</p> <p>In an interview on 4-10-23 at 10:45 a.m., with the Memory Care Unit (MCU) Facilitator, she indicated she has been struggling with staffing for</p>	F 0679	<p>F679 The facility will provide activities programming for the facility's advanced memory care unit.</p> <p>p="" paraid="1050729855" paraeid="{82964fbf-6194-4287-a315-d83b714371a4}{118}"> The corrective action taken for those residents found to be affected by the deficient practice includes: Resident B no longer resides in facility. Resident D activity care plan reviewed and updated. Resident D participates in activities of choice and is being documented on activity log.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All resident assessments and activity logs have been reviewed and updated. Activity aides and nursing staff have been educated on activity programming and</p>	05/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>the activities department. "I used to have several activity staff and I am down to one person for both units. I try to help when I can, but I am the Social Services person for both units and the vent unit, as well as over-seeing the memory care units. So, there are limited staff to help with any activities. I hate it, but I just don't have the people to provide to do activities for both memory care units."</p> <p>In an interview with LPN 3 on 4-12-23 at 10:45 a.m., she indicated the nursing assistants and nurses "do try to help with activities, but we don't have much time for that." She indicated it has been difficult to do much in the way of activities with not having many staff in activities.</p> <p>In an interview with the Activity Director on 4-12-23 at 2:15 p.m., she indicated she assumed the position of Activity Director in recent months and has been primarily responsible for activities programming for the West building, along with one assistant. She indicated the Memory Care Unit Facilitator has assumed responsibility for the East building and has one assistant for both memory care units and the vent unit. She indicated she helps in both buildings as she can, but due to a limited number of activity staff, she can only do so much. "I feel like we are doing much better than when I first came here, but we could use more staff." She indicated the activity programming for the memory care units require a variety of programs due to each residents's abilities and preferences.</p> <p>In an associated interview on 4-12-23 at 3:20 p.m., with the Activity Director, she indicated when she went to print out the activity records for Resident B and Resident D, "there was nothing there to show they had had any activities programming for</p>		<p>documentation.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All resident assessments and activity logs have been reviewed and updated. Activity aides and nursing staff have been educated on activity programming and documentation. Majestic of Connersville has hired 3 activity aides since survey.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The executive director and/or his designee will audit scheduled activities 3x/week for 4 weeks, weekly x 4 weeks and monthly for 6 months. Audits will be random and on both shifts. Activity director will audit 5 residents weekly for 6 weeks for proper activity documentation. Concerns will be brought to QAPI and addressed accordingly. Administrator to monitor.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0921 SS=E Bldg. 00	<p>the last two months. I don't know what to say. The computer documentation shows what we have been working with each resident, whether that is something active or passive. I thought all the activity staff knew how to do that. It looks like we have a lot to work on."</p> <p>The Activity Director provided a copy of Resident B and Resident D's .. for the time period of... Both documents were blank.</p> <p>On 4-12-23 at 2:40 p.m., the Corporate Support Staff provided a copy of a policy entitled, "Activity Programs," with a policy revision date of 7/2018. This policy indicated, "Activity programs designed to meet the needs of each resident are available daily. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities are scheduled 7 (seven) days a week during the day and some evenings and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs. Our activity programs consist of individual and small and large group activities..."</p> <p>This Federal tag relates to Complaint IN00405361.</p> <p>3.1-33(a)</p> <p>483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the dining room floor was free from spills and food for 7 of 7</p>	F 0921	F921 The facility will ensure a clean, sanitary and home like environment.	05/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>residents in the dining area and a resident's bedroom floor was clean for 8 of 18 residents residing on the Advanced Memory Care Unit (AMCU) of the facility reviewed for clean and safe environment.</p> <p>Findings include:</p> <p>1. An observation of the AMCU dining hall on 4-11-23 at 1:27 p.m., indicated the presence of a large amount of medium brown liquid on the central portion of the dining room floor, near and under a circular table with 2 residents present at the circular table, each wearing non-skid socks. At the initial observation, no staff were present in the dining room. An additional five residents were present in the dining room with 5 of the 7 residents wearing non-skid socks and 2 wearing shoes. In addition to the liquid on the floor, food items from the lunch meal of pasta were present on the floor near the circular table. The table was located directly in front of the entrance to the dining room. Within five minutes of the observation, three staff entered the room to begin cleaning the floor. An observation at 1:55 p.m., of the dining room indicated the floor was clean and dry.</p> <p>In interview on 4-11-23 at 2:05 p.m., with CNA 4 and LPN 5, each indicated the lunch meal service had began around noon, and concluded between 1:00 p.m. and 1:30 p.m.</p> <p>2. In an observation of Resident B's room on 4-10-23 at 8:15 a.m., the floor was very sticky to walk on, with small amounts of debris of paper present and appeared dingy.</p> <p>A tour of each resident room and bathroom on the AMCU was conducted on 4-11-12 at 1:35 p.m.</p>		<p>p="" paraid="1050729855" paraeid="{82964fbf-6194-4287-a315-d83b714371a4}{118}"></p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: Resident B no longer resides in the facility.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents residing on the ACMU have the potential to be affected but none were identified. The AMCU dining room was cleaned that day. The large spill and noodles were picked up. Residents B's room was scrubbed x3 to remove the stickiness. Room 313 was scrubbed and buffed.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All other areas of the 300 hall were reviewed and maintained as necessary to ensure a clean, sanitary and home like environment. Nursing staff was educated on 1.) to immediately clean up spills to prevent slips, trips and falls 2.) to assist residents out of dining room when meal has been consumed to allow</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>Resident B's floor remained with a stickiness to it when walked on. In an interview with CNA 4 at this time, she indicated the floor has had the stickiness present for a while (time frame unknown) "because it makes a funny sound on it when you walk on it for a while now."</p> <p>On 4-11-23 at 1:55 p.m., Housekeeper 6 was observed exiting Resident B's room with mop in hand. She indicated she had been trying to work on Resident B's floor's stickiness. "I have been mopping it with hot water to try and get the stickiness to go away." Indicated she is unsure how long the problem has been going on, but is trying to mop the floor at least daily with hot water.</p> <p>An observation on 4-12-23 at 10:25 a.m., indicated Resident B's room floor was clean and dry with minimal stickiness noted when walking across the floor.</p> <p>On 4-12-23 at 2:40 p.m., the Corporate Support Staff provided a copy of a policy entitled, "Safe and Homelike Environment," with a revision date of 2/2023. This policy indicated, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment...Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment..."</p> <p>This Federal tag relates to Complaints IN00403929 and IN00405361.</p> <p>3.1-19(f)</p>		<p>EVS to clean dining room promptly. Areas identified during audit were remedied.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The executive director and/or his designee will complete daily rounds weekly for 4 weeks, 3x a week rounds for 5 months and ongoing.. All information from audit during rounds will be documented and reviewed the following day during morning stand up. All identified areas will be immediately remedied. Concerns will be brought to QAPI and addressed accordingly. Administrator to monitor.</p>	