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	02/02/2022

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 IN00371572, IN00371545 and IN00371097. This visit resulted in an Extended Survey-Substandard Quality of Care- Immediate Jeopardy. Complaint IN00371572- Substantiated. Federal/State deficiency related to the allegations are cited at F-689. Complaint IN00371545 - Substantiated. Federal/State deficiency related to the allegations are cited at F-692. Complaint IN00371097 - Substantiated. Federal/State deficiency related to the allegations are cited at F-692 Survey dates: January 31, 2022 to February 2, 2022 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 29 Medicaid: 53 Other: 33 Total: 115	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 of Correction be considered the Letter of Credible Allegation.** **The provider alleges compliance as of 2-14-2022.** ="" b=""> ="" b=""> ="" b="">	

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 7, 2022			
F 0689 SS=J 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 observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent a cognitively impaired resident who had been exhibiting exit seeking behaviors from exiting the locked memory care unit, obtaining a staff members vehicle and wrecking approximately 1.5 miles from the facility and being sent to the local emergency room for 1 of 3 residents reviewed for elopement (Resident C). The Immediate Jeopardy began on January 21, 2022, when a cognitively impaired resident with dementia exited the locked memory care unit unsupervised. The resident obtained a facility staff' members vehicle, driving the vehicle approximately 1.5 miles from the facility on a state highway where she had wrecked the vehicle and was sent to the local emergency room. The local weather on 1/21/22 was between 14 degrees and 25 degrees. The resident was missing approximately 40 minutes from the	F 0689	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident C was identified during the time of observation. All facility staff will be educated regarding the facility's elopement policy and procedure. Further all staff education on response of audible door alarms; self-latching and door function; and education on reporting of issues with the locking/securing of doors in the TELS system – electronic maintenance orders system that is monitored daily by the Maintenance Director. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/14/2022

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	facility and where she had driven was unknown until the local police was dispatched to her accident on the local highway. The Executive Director and the Director of Nursing Services (DNS) were notified of the Immediate Jeopardy on 2/1/22 at 3:57 p.m. The Immediate Jeopardy was removed on 2/2/22 at 12:55 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record of Resident C reviewed on 1/31/22 at 12:05 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis following cerebrovascular disease affecting the left dominate side, congestive heart failure, Parkinson's disease, diabetes mellitus, major depressive disorder, anxiety disorder, hypertension, osteoarthritis, repeated falls and weakness. The Quarterly Minimum Data (MDS) assessment, dated 12/6/21, indicated the resident was severely cognitively impaired for daily decision making. The resident utilized a wheelchair and walker for mobility. The resident required extensive assistance of one person to transfer and ambulation in her room and corridor happened once or twice with the assistance of one person. The resident was admitted to the facility on 9/10/21. The elopement risk assessment, dated 9/10/21, indicated the resident was low risk for elopement.		action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review of all door locks was conducted to ensure no issues with the locking/securing of facility doors. 3. Audible door alarms were placed on the Alzheimer's Unit (100/200 Halls). 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. All residents will be monitored with site supervision as needed per plan of care at a minimum, and within 2 hour intervals, and all residents will be reassessed per plan of care and as warranted of Resident need. Shift interval audits will be completed by the charge nurse and reviewed daily by the Executive Director/Director of Nursing/Designee until substantial compliance is achieved. 2. Elopement Drills will be completed at a minimum of quarterly and as needed which will be documented.	

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	The elopement risk assessment, dated 1/21/22, indicated the resident was high risk for elopement. The plan of care for Resident C, dated 1/21/22, indicated the resident was at risk for elopement due to exiting seeking behaviors. The resident had a history of attempting to leave the facility unattended and had impaired safety awareness. The interventions were as follows: assess for unmet needs when wandering/exit seeking, such as the need to use the restroom, hunger and thirst. Place the resident's profile in the elopement book. There was no further documentation in the resident's Electronic Health Record (EHR) or hard chart of the incident of Resident C eloping on 1/21/22. During an observation on 1/31/22 at 12:51 p.m., Resident C was sitting in a wheelchair in the main dining room eating lunch independently. During an interview with the Social Service Director (S.S.D.) on 1/31/22 at 12:55 p.m., indicated she was working at the facility on 1/21/22 when Resident C eloped from the memory care unit. The Human Resource staff had found a wheelchair in the parking lot between the memory care unit and the Ventilator unit. The facility found the resident at the local Emergency Room Department. The resident had taken the Respiratory Therapist's van and drove it down the state highway and wrecked in front of another local long-term care facility. The local police department was called, and the resident was sent to the hospital. During an interview with the Human Resource Staff on 1/31/22 at 1:37 p.m., indicated on 1/21/22 she was going from the memory care		3. All residents were reassessed to determine elopement risk and care plans updated as needed. 4. The facility elopement risk binders have been audited to ensure up to date and accurate information. 5. Facility doors will be checked to ensure proper functioning and closure 2 times daily and will be documented. 6. The facility is in process of installing a new wander guard system on the Alzheimer's Units. Installation will be completed the week of 2-14-2022. 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 Executive Director/Director of Nursing/Designee will monitor the nurse 2 hour observations of residents; monitor the 2 times a day documented door checks to ensure proper functioning. Subsequent corrective action and education for identified staff will be completed as needed. 2. Findings will be reported at	

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	unit over to the Ventilator unit and noticed a wheelchair sitting in the south back parking lot. There were no residents observed and this occurred at 3:39 p.m. She knew the exact time because the DNS had called her about an unrelated matter when she found the wheelchair. The Human Resource Staff had used the code on the memory care unit door to exit and did not know it was not working. The wheelchair was brought back into the memory care unit and reported to LPN 1 and the Marketing Director that it had been found in the parking lot and they knew immediately that the wheelchair belonged to Resident C. The Executive Director and the President of the facility was also notified. The staff began searching room to room and outside of the building. During an interview with the Maintenance Director on 1/31/22 at 2:45 p.m., indicated the protocol was he checked doors on Mondays to ensure they were working properly and changed the codes on the doors monthly. The facility did not keep log documentation on when the doors were checked. He would just go around and check the doors. The Maintenance Director indicated the outside exit doors on the memory care unit did not have an alarm system when opened. The facility was in the process of installing security doors that would alarm on the memory care unit and had a security company come out to give the facility an estimate. The Maintenance Director was working on 1/21/22 when the resident eloped from the memory care unit. The facility was unsure how the resident was able to exit the door. He stated it could have been the weather, a vacuum from the wind that did not let the door shut all the way, or maybe the resident had followed someone out of the door. The Maintenance Director checked the door on		the QA meeting monthly or until substantial compliance has been determined.	

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	1/21/22 and could not find anything malfunctioned on the door. He changed the code to the door that evening. During an interview with LPN 1 on 2/1/22 at 10:33 a.m., indicated he was the dedicated nurse for the memory care unit and was working on 1/21/22 when Resident C eloped the facility. LPN 1 had seen the resident approximately 15-20 minutes prior to the wheelchair being found. The resident had been propelling herself in the wheelchair prior to the incident. Resident C could ambulate but was unsteady. The resident did have a history of talking about wanting to go home and hovering around the exit doors. LPN 1 indicated the exit door to the outside on the memory care unit did not always close all the way unless you physically closed it. There was about an inch gap that kept the magnet from activating to lock it, but the door would look like it was closed. The door started doing this in late fall and got worse as the weather got colder. The staff utilized the door to go from the memory care unit over the Ventilator unit but were not allowed to any longer since this incident happened. When queried if the Maintenance Director was aware that the door had been malfunctioning, LPN 1 indicated "anyone who used the door knew that it had to be physically shut". During an interview and observation with Resident C on 2/1/22 at 11:10 a.m., indicated she had drove a van from the facility and had hit a large rock and wrecked it. The resident indicated she was able to leave the memory care unit because the door was open. The resident indicated she did not remember where all she had drove or where she was going, but knew she wanted to go anywhere but the facility. The			

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	resident indicated she did not belong at the facility, and she had been "dropped off" there for no reason. The resident began crying and indicated she wanted to go home. The resident was observed to be lying in bed and sat up on the side of her bed during the interview. The S.S.D. was notified of the resident becoming tearful. During an interview with the DNS on 2/2/22 at 11:21 a.m., indicated on 1/21/22 Respiratory Therapist 1 had gone to his van for a break and thought his keys to the van may have dropped out of his jacket when he was getting out of the van to come back into the facility and that was how Resident C was able to take the van from the facility. During an observation and interview with the Executive Director and the Maintenance Director on 2/1/22 at 11:35 a.m., the exit door to the outside on the memory care unit had a keypad code that only the Executive Director and Maintenance Director had now was activated by the Maintenance Director. The door was opened 6 times on both sides of the door and the magnet that locked the door would activate between 9 to 16 seconds after the door was closed. The back south parking lot was observed where the wheelchair was located, and it was located behind the memory care unit and the ventilator unit. There was a sidewalk leading from the memory care unit to the Ventilator unit and a sidewalk leading to the parking lot, there was grassy areas between the sidewalk and a field behind the parking lot. The Maintenance Director indicated staff used to park in the back parking lot because it was closer to the unit and now, they were not. During an interview with the DNS on 2/1/22 at 12:01 p.m., indicated she went to the local			

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	Emergency Room on 1/21/22 and stayed with Resident C unit she returned back to the facility. The DNS had completed an assessment on Resident C upon return to the facility but had not documented it. The DNS was going to document a late entry of the assessment at this time. During an interview with the Administrator on 2/1/22 at 12:15 p.m., the facility did not document Maintenance logs for repairs. The facility did not have documentation of a repair requisition for the memory care unit exit door. During an interview with Resident C's family member on 2/1/22 at 12:28 p.m., indicated the facility had notified him on 1/21/22 that his family member Resident C had eloped the facility and they were unsure how. The family member indicated every time they visited the resident, the resident expressed her desire to leave the facility. The resident did not comprehend that she was unable to leave the facility. The family member was notified by the Marketing Director that the resident had a history of going to the doors on the memory care unit and would yank on the exit doors to attempt to open them. The resident was unable to tell him where she had drove to or where she was going. She told him she was lost. The resident was able to tell him that she hit a rock and wrecked the van. The family member indicated the facility "obviously failed" the resident because she was in a locked memory care unit and was able to get out in a wheelchair. The keys had to be left in the vehicle because how else would she have known what vehicle to take and get the keys. The family member indicated he was "unable to wrap his mind around how she got out and left the facility and drove away."			

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	During an interview with the Executive Director on 2/1/22 at 12:49 p.m., indicated he was unable to locate the last elopement drill the facility had completed. The Executive Director indicated there was no family members who had screened in the facility to access the memory care unit on 1/21/22 when the resident eloped. During an interview with the Marketing Director on 2/2/22 at 12:52 p.m., indicated she had worked with Resident C and the resident had a history of exit seeking. The resident would wheel her wheelchair up to the exit door and pull and push on the lever to check the door repeatedly. The resident would wheel around the unit and check the doors and often tried to trail out behind people when they leave the unit. The local police report, dated 1/21/22 at 3:59 p.m., indicated a deputy was dispatched to a local address on the state highway in reference to an unknown accident. Upon arrival Emergency Medical Services (EMS) was speaking with Resident C. Resident C "appeared to have no idea where she was at and appeared to be having a medical issue." Upon looking at the vehicle it had struck a rock and had caused damage to the front passenger side headlight are and front passenger side tire. The vehicle had been parked in the parking lot of a local facility. Dispatch received a call from the local long-term care facility advising "a patient had escaped from their facility and had taken a workers van." Dispatch advised the patient was transported to the local Emergency Room for medical treatment and that she had been involved in an accident. This indicated the resident was missing approximately 40 minutes from the facility when LPN 1 visualized the resident on 1/21/22 at 3:19 p.m. and was not seen until the local police found her			

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	on 1/21/22 at 3:59. The local hospital Emergency Room report for Resident C, dated 1/21/22 at 5:41 p.m., indicated the resident had run over a small decorative rock and had no apparent injuries. The resident was able to state where she was and her birth date. The resident's orientation "waxes and wanes." She indicated she was on her way to see her parents, getting married and was pregnant. "She denies any complaints and states that she feels well." Apparently, she was found by another local long-term facility that was not familiar with her and they called EMS. "Apparently, patient is a resident at the local Extended Care Facility (ECF) and was on their dementia unit and they had just called dispatch due to patient escaping the facility." "Apparently she had stolen a therapist's van somehow and they found her wheelchair in the parking lot." The resident had "absolutely no complaints or obvious injury." According to Accu Weather the local weather where the facility is located was between 14 degrees and 25 degrees on 1/21/22, https://www.accuweather.com/en/us. The elopement policy provided by the DNS on 1/31/22 at 2:30 p.m., indicated the care team members who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action was taken. Elopement drills would be conducted quarterly. The Immediate Jeopardy that began on 1/21/22 was removed on 2/2/22 at 12:55 p.m., when the facility implemented checking all doors to ensure proper functioning two times a day and documenting the door checks, changing door			

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	codes every 30 days, implementing audible door alarms to the memory care unit exit doors, monitoring all residents at a minimum of every two hours and implementing audits for completion, and educating staff on reporting of issues with the locking/securing of doors. This Federal tag relates to Complaint IN00371572. 3.1-45(a)(1) 3.1-45(a)(2)			
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 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.	F 0692	1. What corrective action(s)	02/14/2022

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	Based on record review and interview, the facility failed to obtain weights according to physician's orders and the facility policy for 3 of 3 residents reviewed for nutritional status. (Residents E, G, and H) Findings include: 1. Resident E's record was reviewed on 1/31/22 at 2:10 p.m. The record indicated Resident E had diagnoses that included but were not limited to, type 2 diabetes mellitus, depression, acute kidney failure, and anxiety. An Annual Minimum Data Set assessment, dated 11/23/21, indicated Resident E was cognitively intact, did not walk during the assessment period, required one person assist for eating, and used a wheelchair. A care plan, last revised on 12/27/21, included, but was not limited to, a focus for potential nutritional risk related to chronic obstructive pulmonary disease, obesity, type 2 diabetes mellitus, food allergies and sometimes refuses weights. Interventions included, but were not limited to, "...Weights as ordered/indicated, notify MD of significant weight changes. Work with resident on identifying good time to be weighed." Physician's orders, dated 1/1/22, indicated weekly weights x 4 weeks on day shift every Saturday. The most recent documented weights and dates were: 12/3/21 - 240 9/2/21 - 215		will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) E, G and H were identified during the time of observation. All clinical staff have been educated on the facility policy of obtaining resident weights according to physician's orders. 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 within the last 30 days have been weighed per physician order. 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. Director of Nursing/Designee will complete an audit 1 time a week x8 weeks then monthly ongoing to ensure resident weights are obtained according to physician's orders. The plan will be revised, as warranted.	

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(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
	There were no other monthly or weekly weights in the clinical record. 2. Resident G's record was reviewed on 2/1/22 at 11:00 a.m. The record indicated Resident G had diagnoses that included, but were not limited to, morbid obesity due to excess calories, Alzheimer's disease, anxiety, and type 2 diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 11/29/21, indicated Resident G was cognitively intact, height was 60", weight was 223, she has had weight loss in the last 6 months, and required extensive assistance of one for eating. A care plan, last reviewed on 12/17/21, indicated a focus that Resident G had a potential for nutritional risk due to type 2 diabetes mellitus, depression, Alzheimer's disease, morbid obesity and therapeutic diet. A goal was that she would not have a significant weight change. Interventions included but were not limited to; "...Weights as ordered/indicated, notify MD of significant weight changes." The care plan also indicated she had a significant weight loss in the last 30 days. A physician's order, dated 12/9/21, indicated weekly weights times 4. Those were signed off on the Treatment Administration Record as done, but the weights were not recorded. The most recent weights obtained were: 1/7/22 - 256 11/23/21 - 223 There were no other weekly or monthly weights		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 Director of Nursing/Designee will review any findings weekly, 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.	

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	02/02/2022

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	in the clinical record. 3. The clinical record for Resident H was reviewed on 2/1/2022 at 11:42 a.m. The diagnoses included, but were not limited to, Barrett's esophagus with dysplasia, gastro-esophageal reflux disease, and weakness. A Quarterly Minimum Data Set for Resident H, dated 12/7/2021, indicated that she was cognitively intact and needed supervision with eating. This assessment also indicated she had a non-prescribed weight-gain in 5% in 1 month or 10% in 6 months. A weight variance care plan for Resident H, revised on 12/17/2021, indicated to obtain weights as ordered/indicated and to notify the medical doctor of significant weight changes. Weights for Resident H were as followed: 8/4/2021 at 129 pounds 8/9/2021 at 131 pounds 8/12/2021 at 141 pounds 9/2/2021 at 139 pounds 10/5/2021 at 140 pounds 11/1/2021 at 139 pounds 12/3/2021 at 167 pounds 2/1/2022 at 140 pounds An interview with the Director of Nursing Services on 2/1/2022 at 12:20p.m. indicated that residents would have monthly weights at a minimum and then follow the weight monitoring policy if any significant changes. A policy entitled, "Resident Weight Monitoring", was provided on 2/2/2022 at 10:05 a.m. with an origin date of October 2018 with no revision date. The policy indicated, "... Weekly weights			

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	will be obtained and recorded in the EMR [Emergency Medical Record] ...A weight report will be generated monthly and reviewed by the DM [Dietary Manager], RD [Registered Dietician], DNS [Director of Nursing Services], and MDS [Minimum Data Set] for significant changes. A significant change is defined as 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. The resident's physician and family/guardian will be notified of any significant weight change ... Verify re-weighs will be indicated in the EMR as a correction//edit to the initial weight recorded. If the resident declines to be weighed, documentation will be made in the EMR that the weight was not taken. Weekly weights: Should be taken on a designated day each week ...residents exhibiting significant weight changes ...Monthly weights: Should be taken by the 5th of the month and recorded in the EMR vital section Residents will be re-weighed/verified if a weight change of +/- 5lbs [pounds] in a month is noted. Re-weights should be completed by the 6th of the month and will be reflected in the EMR ....[sic]" This Federal tag relates to Complaints IN00371097 and IN00371545. 3.1-46(a)(1)			