STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. Building B. Wing	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Connersville	1029 E 5th Street Connersville, IN 47331

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review the facility failed to ensure a resident with an ongoing odor to a wound and elevated temperatures was followed-up with that resulted in hospitalization with osteomyelitis (Resident D), ensure a resident with increased respiratory workload and blood tinged secretions was followed-up with timely that resulted in hospitalization with sepsis and respiratory failure (Resident C), and ensure a resident who was reported as diaphoretic overnight was followed-up with timely resulting in hospitalization with septic shock (Resident B) for 3 of 5 residents reviewed for change in condition. Findings include: 1. The clinical record for Resident D was reviewed on 4/27/22 at 2:00 p.m. The diagnoses included, but was not limited to, tracheostomy status, gastrostomy status, weakness, diabetes mellitus, and age-related physical debility. Resident D was admitted to the facility on [DATE]. An admission assessment, dated 1/7/22, indicated Resident D had an unstageable pressure ulcer to the coccyx upon admission. There were no measurements or further assessment included. Resident D was hospitalized from 1/7/22 to 1/11/22. A readmission assessment, dated 1/11/22, indicated an unstageable pressure ulcer to the coccyx but no measurements or further assessment included. A wound assessment, dated 1/26/22, indicated an unstageable pressure ulcer to the coccyx measuring 12 x 6 x 0.2 centimeters in depth that was acquired on 1/25/22. It was listed currently as a Stage 1 and originally a deep tissue injury. Resident D was hospitalized from 1/26/22 to 1/27/22. A readmission assessment, dated 1/28/22, indicated a wound to the coccyx but no staging, measurements, or further assessment included. Resident D was hospitalized from 2/9/22 to 2/11/22. A readmission assessment, dated 2/11/22, indicated a wound to the coccyx but no staging, measurements, or further assessment included. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A pressure ulcer assessment, dated 2/18/22, indicated covers coccyx and continues to bilateral buttocks. Acquired on 1/25/22 and measured 12.5 x 13 x 0.2 centimeters. It was listed as unstageable and worsening with 95% necrotic tissue and 5% granulation tissue. The treatment was to apply Santyl to necrotic areas. A pressure ulcer assessment, dated 2/23/22, indicated an unstageable wound to coccyx that measured 13 x 13.5 x 0.2 centimeters in depth. The wound was unchanged. The treatment was to apply Santyl to the necrotic tissue and calcium alginate to the small areas to the outer wound bed that were granulated. A pressure ulcer assessment, dated 3/2/22, indicated an unstageable wound to coccyx measuring 12.2 x 14. 2 x 4 centimeters in depth. the date acquired was 2/18/22 and the wound consisted of 25% slough, 50% necrosis, and 25% granulation tissue. Infection was suspected due to fever, slight greenish color to some areas. A progress note, dated 3/3/22 at 4:01 p.m., indicated the following, .resident was seen 1 week ago by this writer and wound consultant nurse with wound to coccyx measuring 12.5 L [length] x 13.0 W [width] x 0.2 D [depth] and having 95% necrotic tissue and 5% granulation. Orders were put in to resident's record of Medihoney to necrotic tissue and Calcium Alginate to the granulated area. Wound re-evaluated today with significant changes noted .Call placed to wound consultant nurse as she was not on site today and explained all of the above. It is her belief that this may be a [NAME] Wound as resident did recently code and this may be the result d/t [due to] the quickness that this wound presented in such a large area .Treatment to area changed to applying Santyl Ointment to all necrotic and slough areas and cutting strips of Calcium Alginate to size for areas of granulation, then cover and secure daily A Medical Director (MD)/Nurse Practitioner (NP) Progress Note, dated 3/3/22 at 12:52 p.m., indicated a sacral ulcer with tunnelling and blackened tissue. Treatment with 1/4 dakins solution, wet to dry every 8 hours. Wound care for debridement for placement of wound vac. The note indicated that nursing was aware of orders. A progress note, dated 3/7/22 at 4:28 p.m., indicated the following, .noted large amount of purulent [consisting of pus] drainage coming from the wound during wound care today. She also stated that resident had temp [temperature] of 99.9 earlier in shift, but came down following administration of Tylenol .[name of Nurse Practitioner] was notified of concern over wound with possibilities of sepsis and/or Osteomyelitis developing. Explained that facility had notified Wound Healing Services as it was felt the wound needed debridement, but unable to get resident to an appointment due resident relies on ventilator for airway and they do not have a traveling nurse that would be able to come to the facility. He stated that another NP [Nurse Practitioner] within their network was Wound Certified and would be notified to come and assess the wound with possible debridement to take place her [sic] at the facility. Awaiting notification for when to expect NP to come to facility for assessment. A pressure ulcer assessment, dated 3/9/22, indicated an unstageable wound to coccyx measuring 14.8 x 11 x 4.8 centimeters in depth. There was 40% slough, 40% necrotic, and 20% granulation tissue. There was infection suspected marked possible with intermittent low-grade fevers. Treatment was to add Dakins 1/2 strength with a wet-moist dressing along with Santyl and calcium alginate. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A pressure ulcer assessment, dated 3/16/22, indicated an unstageable wound to coccyx measuring 14.6 x 13.5 x 0 centimeters in depth with 75% necrotic and 25% slough tissue. There was a foul odor with infection suspected due to foul odor, intermittent fever. The treatment was changed to Santyl and calcium alginate. Resident D was discharged to the hospital, on 3/22/22, due to having a low hemoglobin level. There was no mentioning of the wound. A physician order, dated 3/22/22, was noted for Clindamycin (antibiotic) 300 milligrams every 6 hours for infection until 3/28/22. There was no indication on what infection the antibiotic was used to treat. A progress note, dated 3/29/22 at 6:36 a.m., indicated the following, .remains on atb [antibiotic] for buttock wound A progress note, dated 3/30/22 at 3:40 p.m., indicated the following, .Patient had a temp [temperature] this am [A.M.] of 99.5. this afternoon she spiked up to 102.3 .Sent a message to [name of NP]. I am waiting for his response A pressure ulcer note, dated 3/30/22, indicated an unstageable to coccyx that measured 13.5 x 12 x 4.2 centimeters in depth. There was documentation of purulent drainage and foul odor. The antibiotic was completed for the buttock wound and documentation consisted of Resident D's skin remaining diaphoretic. A pressure ulcer note, dated 4/6/22, indicated an unstageable to coccyx that measured 11.1 x 11.6 x 2.7 centimeters in depth. There was no odor documented. A pressure ulcer note, dated 4/13/22, indicated an unstageable to the coccyx measuring 13.7 x 13.4 x 2.4 centimeters in depth. There was a foul odor documented with moderate drainage. A progress note, dated 4/14/22 at 12:14 a.m., indicated Resident D's skin was pale and diaphoretic. There was no follow-up to the progress note, dated 4/14/22, about Resident D's pale skin and being diaphoretic. A progress note, dated 4/19/22 at 12:01 p.m., indicated Resident D was sent to the emergency room (ER) due to having a low hemoglobin level. An emergency room note, dated 4/19/22, indicated Resident D arrived at the ER with an elevated temperature of 104.4 and a very large and deep sacral wound with packing with purulence material. An abdominal CT (Computed Tomography) scan, completed 4/19/22, indicated a Large sacral decubitus ulcer with osteomyelitis of the distal sacrum and coccyx. A hospital admission note, dated 4/19/22, indicated the following, .Impression and plan .2. Large sacral decubitus and osteomyelitis .3. Probably right pelvic abscess possibly related to fistula formation . Recommendation .Surgical evaluation of sacral decubitus .Interventional radiology to drain right pelvic abscess .Palliative care evaluation (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Palliative Care Note, dated 4/21/22, indicated the following, .She was evaluated by surgery on 4/20/22 for a large stage IV sacral decubitus ulcer with exposed bone. Unfortunately, the area cannot be debrided-there is only pelvic muscle. Orthopedics was consulted and recommended IR-guided aspiration of left hip joint effusion. Orthopedics and General surgery do not recommend surgical interventions, and wound Care will follow the patient An interview conducted with the Director of Nursing Services (DNS), on 4/29/22 at 2:15 p.m., indicated the slough tissue, which is dead tissue, does have an odor to it. They were treating Resident D's wound aggressively. If someone had a wound that wasn't odorous, and it suddenly developed an odor that would be a change in the status of the wound. 45291 2. The clinical record for Resident B was reviewed on 4/27/2022 at 2:19 p.m. The clinical diagnoses included, but were not limited to, gastrostomy status and dependence on a respirator. A Quarterly Minimum Data Set (MDS), dated [DATE], indicated that Resident B did not have memory issues, did not reject care, and dependent on staff members for all care that included tasks of feeding, hygiene, and bed mobility. Resident B received her nutrition via tube feeding at least 51% of more of her daily needs, had four stage 2 pressure ulcers, and utilized oxygen and a ventilator in the presence of a tracheostomy (trach). A brief interview for mental status to assess cognitive status was not completed due to resident is rarely/never understood. A change of condition assessment, dated 3/9/2022 at 9:00 a.m., indicated Resident B had abnormal vital signs, altered mental status, new/worsening edema, functional decline, skin wound or ulcer, unresponsive, seems different than usual, talks/communicates less, tired, weak, confused, or drowsy, and change in skin color or condition. This assessment further indicated that Resident B was diaphoretic, had no cough reflex, was very edematous, and staff were unable to assess her blood pressure. In the 24 hours prior to the change of condition note on 3/9/2022 at 9:00 a.m., no documentation of diaphoresis, intervention, or change in condition. A hospitalist emergency room (ER) note for Resident B, dated 3/9/2022 at 9:53 a.m. indicated that .nursing from extended care facility reports the patient was clammy and diaphoretic and cool to the touch all night . Later during med pass this morning she was noted to heave decreased responsiveness. They performed aggressive suctioning without gag reflex . was noted to be pale . Her temperature was listed as 100.3 Fahrenheit (normal is 97.6 F), and blood pressure was listed as 40/0 (normal is 120/80). The ER documentation further indicated, .patient [Resident B] presents here with unresponsiveness and has finding suggestive of septic shock . An interview with LPN 3 (Licensed Practical Nurse) on 4/28/2022 at 1:44 p.m., indicated she had taken care of Resident B the morning she was sent to the ER. She indicated usually the resident could nod yes or no, but that was about it, but she was unresponsive that morning. In report, the off going nurse stated her urinary catheter was leaking and Resident B had a rough night, but LPN 3 did not get any other information in report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview with LPN 11 on 4/29/2022 at 12:30 p.m., indicated Resident B was diaphoretic on and off since she returned from the hospital in early March, but was more so during the end of her stay (3/9/2022) and that diaphoresis would be an acute symptom to warrant intervention such as vital signs and at least a note due to her clinical complexity. She felt Resident B was never the same after her first round of being hospitalized in February and March of 2022. An interview with RT 2 (Respiratory Therapist) on 4/29/2022 at 12:43 p.m., indicated he had cared for Resident B during her stays at the facility and if she ever had a fever or was diaphoretic, he would have reported it to the nurse. 3. The clinical record for Resident C was reviewed on 4/27/2022 at 3:39 p.m. The medical diagnoses included, but were not limited to, acute respiratory failure with hypoxia and gastrostomy tube. The non-comprehensive Minimum Data Set Assessment, dated 4/13/2022, indicated that Resident C was cognitively intact, needed extensive assistance of staff for bed mobility, locomotion, dressing, toileting, and hygiene. Resident C was totally dependent on staff for transferring and bathing tasks. Resident C was indicated as having a tracheostomy present and to have received 51% or more of her daily national value by gastric tube. Resident C utilized oxygen with the presence of a trach. A nursing admission/readmission evaluation, dated 4/7/2022, indicated that Resident C's respirations were regular/unlabored and only have shortness of breath with exercise. A nursing assessment, dated 4/11/2022 at 3:31 a.m., indicated Resident C's respirations were labored/accessory muscles used, had abnormal lung sounds of diminished, and shortness of breath with lying flat. Assist control ventilation is a form of ventilation that provides a fully supported breath with oxygenation given via ventilator. A speaking value is a one-way valve opens to let air in through the trach when the patient inspires. The valve closes during expiration, causing the air to follow the normal route and permitting speech. Oxygen given by tracheostomy collar is given by a small plastic mask that is placed over the exterior end of a tracheostomy that allowed the resident to receive humidified oxygen without breath support. A ventilator flow sheet, dated 4/10/2022 at 8:00 a.m. to 4/11/2022 at 6:00 a.m. indicated think white secretions and resident was on a speaking valve with 10 liters of oxygen via trach collar from 8 a.m. to 6 p.m. then increasing oxygen flow rate to 20 liters on the speaking valve with trach collar at 8 p.m. The resident was switched to assist control ventilator at 12:00 am on 4/11/2022. A ventilator flow sheet, dated 4/11/2022 at 8:00 a.m. to 4/12/2022 at 6:00 a.m., indicated blood-tinged secretions and was on assist control throughout the whole day. A nursing progress note, dated 4/12/2022 at 9:00 p.m., indicated New orders for .D-Dimer [lab to test a certain clotting factor] and 2 view CXR [chest x-ray] .High pressure alarm continues to go off but a lot [sic] of blood is being suctioned out and attempting to not place to much negative pressure into resident lungs. Will continue to monitor . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A nurse practitioner note, dated 4/12/2022 at 9:50 p.m., indicated .Anxious appearing, respiratory rate elevated. Reported not feeling she was getting complete breaths, mild diaphoretic .Tracheostomy- stat CXR . d-dimer. A nursing progress note, dated 4/12/2022 at 11:30 p.m., indicated .resident continues to high pressure with prn suctioning of blood and clots. SpO2 @ [Saturation pulse oxygen level at] 98% on 14L [Liters]. respirations at 38 with abd [adnominal] labored breathing .daughters updated on labs and stated they are tired of farting around [sic] and waiting for everyone to come to facility and that they are wasting precious time. They are wanting their mother sent to hospital. Contacted [Name of nurse practitioner] updated on everything nurse has done to keep resident at facility and to give in house treatment but family is persistent of resident being transferred to hospital. Order received at this time to send resident to ER [emergency room] .ER. 911 contacted to transport resident to ER. A hospital discharge note containing the hospital course summary, dated 4/21/2022, indicated Resident C was admitted from the facility .with several says of increase trach secretions, increased work of breathing, blood around trach, and hemoptysis [bloody sputum] .Patient [Resident C] was admitted to the hospital for septic shock due to pneumonia . An interview with LPN 11 on 4/29/2022 at 12:30 p.m., indicated she only took care of Resident C one time right after her admission and that Resident C's condition was very touchy. An interview with RT 2 (Respiratory Therapist) on 4/29/2022 at 12:43 p.m., indicated he had cared for Resident C and in his opinion, she was the most clinically unstable resident he had cared for in regard to her respiratory status. Resident C would go from a low demand on trach collar to needing to requiring high flow or assist ventilation rapidly. Resident C would state, She can't breathe, was noted to have high anxiety, and prior to her going out [to the ER] that she wouldn't sync with her ventilator. He recalled having multiple conversations with nursing staff about his concerns for her anxiety and respiratory status. A policy entitled, Change in Condition, was provided by the Director of Nursing Services (DNS) on 4/28/2022 at 11:00 a.m. The policy indicated that for a life-threatening change in condition, the licensed nurse will initiate appropriate first aid until emergency response arrives, the licensed nurse will inform the attending physician or medical director, the responsible party of the residents, and notify the DNS and Executive Director (ED). An acute change of condition was any sudden or serious change in the resident's condition that would be communicated to the physician and the responsible party would be notified. This Federal tag related to Complaint IN00378410. 3.1-37(a)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45291 Based on interview, observation, and record review the facility failed to check placement and identify potential signs of displacement for Resident B, and failed record residual gastric contents of a gastrostomy tube (g-tube) prior to administration of tube feedings and medications for 2 residents (Resident B and C) resulting in hospitalization for septic shock and necrotizing fasciitis of the abdominal wall, rectus abdominus, and rectus sheath, resulting in death (Resident B), and failed to ensure a follow-up with a gastroenterologist (GI) or replacement of a dislodged g-tube (Resident E) for 3 of 5 residents reviewed for g-tube management. This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when Resident B experienced a change in condition resulting in hospitalization with a displaced g-tube and findings consistent with necrotizing fasciitis and infection in the peritoneal cavity that resulted in Resident B dying on [DATE]. The Executive Director (ED), Director of Nursing Services (DNS), and Administrator in Training were notified of the Immediate Jeopardy on [DATE] at 4:37 p.m. The Immediate Jeopardy was removed on [DATE], 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: 1. The clinical record for Resident B was reviewed on [DATE] at 2:19 p.m. The clinical diagnoses included, but were not limited to, gastrostomy status and dependence on a respirator. A Quarterly MDS, dated [DATE], indicated that Resident B did not have memory issues, did not reject care, and dependent on staff members for all care that included tasks of feeding, hygiene, and bed mobility. Resident B received her nutrition via tube feeding at least 51% of more of her daily needs and had four stage 2 pressure ulcers. A brief interview for mental status to assess cognitive status was not completed due to resident is rarely/never understood. No MDS Assessment documented after return to facility on [DATE]. A hospitalist note, dated [DATE], indicated that Resident B would not be able to communicate even with a translator per her son. An eternal feeding care plan for Resident B, dated [DATE], indicated the intervention of checking for tube placement and gastric contents/residual volume per facility protocol and record. A ventilator care plan, dated [DATE], indicated an intervention of Provide alternated methods of communication for the resident (Specify) with no further specification for Resident B. A physician order for Resident B, dated [DATE], indicated a diet order of nothing by mouth. A physician order for Resident B, dated [DATE], indicated cleanse g-tube site with soap and walker daily and as needed, apply a drain sponge daily and as needed, and may be left open to air if clean and no drainage. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician order for Resident B, dated [DATE], indicated decreased tube feeding to 25 ml for 72 hours. A physician order for Resident B, dated [DATE], indicated flush tube prior to and after medications administration with (blank) milliliters water every shift. A physician order for Resident B, dated [DATE], indicated continuous feeding formula: (blank), cc (cubic centimeters)/hour 60 x 24 hours on for 24 hours and to document total volume of ml (milliliters)/24 hours. A physician order for Resident B, dated [DATE], indicated Glucerna 1.2 (type of enteral feeding) to be given at 50 ml/hour. No order present to check or document placement or to check residual of g-tube prior to administration or initiating feedings for Resident B. Neither the medication administration record (MAR) nor treatment administration record (TAR) for [DATE] indicated checking placement of Resident B's g-tube. Neither the MAR nor TAR indicated documentation of residual volume for Resident B. The MAR indicated the order for decreased feeding 25 ml for 72 hours was not signed off on [DATE]. The orders for decreased feeding 25 ml for 72 hours and for Glucerna 1.2 at 50 ml/hour were signed off on [DATE]. The Glucerna 1.2 at 50 ml/hour continued to be signed off on [DATE]. The MAR indicated that Resident B's enteral feeding volume was recorded every shift (twice a day) as follows: [DATE] as 1200 ml for day shift and 1200 ml for night shift, [DATE] as on for day shift and 600 ml for night shift, [DATE] as 1200 ml for day shift and 50 ml for night shift, [DATE] as 1200 ml for day shift and 50 ml for night shift, [DATE] as 50 ml for day shift and 50 ml for night shift, and no documentation for [DATE]. A change of condition assessment, dated [DATE] at 9:00 a.m., indicated Resident B had abnormal vital signs, altered mental status, new/worsening edema, functional decline, skin wound or ulcer, unresponsive, seems different than usual, talks/communicates less, tired, weak, confused, or drowsy, and change in skin color or condition. This assessment further indicated that Resident B was diaphoretic, had no cough reflex, was very edematous, and staff were unable to assess her blood pressure. In the 24 hours prior to the change of condition note on [DATE] at 9:00 a.m., no documentation of diaphoresis, intervention, or change in condition. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospitalist emergency room (ER) note for Resident B, dated [DATE] at 9:53 a.m. indicated that .nursing from extended care facility reports the patient was clammy and diaphoretic and cool to the touch all night . Later during med pass this morning she was noted to have decreased responsiveness. They performed aggressive suctioning without gag reflex . was noted to be pale . Her temperature was listed as 100.3 Fahrenheit (normal is 97.6 F), and blood pressure was listed as ,d+[DATE] (normal is ,d+[DATE]). [NAME] blood cells were indicated 34.3 x 109/L with a normal range of 4XXX,d+[DATE] x 109/L. An elevated white blood cell count can be indicative of an infection. Her lactic acid was listed as >9.9 MMOL/L (millimoles per liter) with a normal of 0.5 to 2.2 MMOL/L. Elevated lactic acid can be indicative of sepsis or a severe inflammatory response syndrome. The ER documentation further indicated, .patient [Resident B] presents here with unresponsiveness and has finding suggestive of septic shock . A computed tomography (CT) scan abdomen and pelvis with intravenous (IV) contrast, dated [DATE], indicated that Resident B had a gastric tube present with the tip located in the anterior abdominal wall at the level of the left rectus abdominus. There is extensive air within the left rectus extending to the right rectus inferiority as well as fat and peritoneal cavity consisting with necrotizing fasciitis and infection. A hospitalist note from [DATE], indicated that Resident B had a g-tube in malposition. The note stated, .Give the location of the cuff under the skin, it is likely that the tube has been dislodged for some time and patient was getting tube feeds and medications until yesterday. [[DATE]] I removed the G-tube and there is no foul odor emanating from the site .this is likely subcutaneous infection from tube feed .: A CT scan of abdomen and pelvis without IV contrast, dated [DATE], indicated .There is a ventral abdominal wall air due to malpositioned G-tube along the left abdominal rectus muscle and extending across the lower ventral abdominal wall in the pelvis with generalize inflammatory changes . A CT scan of abdomen and pelvis without IV contrast, dated [DATE], indicated .There is again seen air in within the subcutaneous soft tissue rectus muscle consistent with necrotizing fasciitis extending down into the anterior lower pelvis and deep fascial plane within the pelvis itself. When compared to the previous study appears slightly worse. Physician physical examination of Resident B, dated [DATE], indicated, .Patient was evaluated early in the morning .She had bilateral upper and lower extremity edema, she had erythema was been turning darker in the abdomen and groin our areas as well as upper thighs, she was in a morphine drop, she was grimacing [sic] A discharge summary hospitalist note for Resident B, dated [DATE], indicated that .she developed septic shock requiring pressure support due to necrotizing fasciitis infection of the abdomen. GI consulted, patient needs to high risk for any intervention at this time. General surgery on board due to necrotizing fasciitis of the abdominal wall, rectus abdominus rectus sheath .General surgery, intensivist, report that treatment is futile . family agreed patient should be made comfort care. Patient expired with presence of family on [DATE] at 14:53 p.m . [sic] Discharge diagnoses included, but were not limited to, multifactorial septic shock and necrotizing fasciitis of the adnominal wall. Licensed direct care staff present on unit during investigation were not employed at the time of the event on [DATE] for Resident B. (continued on next page)

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	155491	A. Building B. Wing	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Connersville	1029 E 5th Street Connersville, IN 47331

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The clinical record for Resident C was reviewed on [DATE] at 3:39 p.m. The medical diagnoses included, but were not limited to, acute respiratory failure with hypoxia and gastrostomy tube. The non-comprehensive Minimum Data Set Assessment, dated [DATE], indicated that Resident C was cognitively intact, needed extensive assistance of staff for bed mobility, locomotion, dressing, toileting, and hygiene. Resident C was totally dependent on staff for transferring and bathing tasks. Resident C was indicated as having a tracheostomy present and to have received 51% or more of her daily national value by gastric tube. An eternal feeding care plan for Resident C, dated [DATE], indicated the intervention of checking for tube placement and gastric contents/residual volume per facility protocol and record. A tracheostomy care plan for Resident C, dated [DATE], indicated the potential for difficulty with communication with the interventions of provide means of communication and use alternative communication tools as needed. A physician order for Resident C, dated [DATE], indicated a diet of nothing by mouth. A physician order for Resident C, dated [DATE], indicated enteral feeding every 24 hours for nutrition continuous per g-tube. A physician order for Resident C, dated [DATE], indicated flush tube with 100 ml (milliliters) of water every 4 hours. A physician order for Resident C, dated [DATE], indicated enteral feed ordered every shift for nutrition at 55 ml/hour. A physician order for Resident C, dated [DATE], indicated vital 1.2 (a type of enteral feeding) at 65 ml/hour via continuous feed pump per g-tube. A physician order for Resident C, dated [DATE], indicated enteral feed order of flush tube with 5 ml of water between each medication. A physician order for Resident C, dated [DATE], indicated to check placement of tube prior to administration of meds and tube feeding. A physician order for Resident C, dated [DATE], indicated to cleanse g-tube with soap and water and apply drain sponge daily and as needed. May be left open to air if no drainage. A physician order for Resident C, dated [DATE], indicated to flush tube with 60 ml before and 60 ml after medications. A physician order for Resident C, dated [DATE], indicated continuous feeding formula: (blank) cc/hour: (blank) x (blank) hours on: (blank) and off (blank) with a total volume of ml/24 hours. No order to document residual indicated on Resident C's chart. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The MAR and TAR for Resident C were reviewed and no documentation present for total volume of feedings located on the MAR. The order to check placement for the g-tube were signed off on [DATE] and [DATE] without documentation of residual. A nursing progress noted, dated [DATE], indicated that the Resident C was having an elevated blood pressure, increased respirations, and abdominal labored breathing. Family wanted Resident C sent to the hospital because they are tired of farting around and waiting for everyone to come to the facility and they are wasting precious time. [sic] Resident C's provider was contacted and updated before the order was received to send Resident C to the ER. An ER physician note, dated [DATE] at 6:37 a.m., indicated that Resident C had sepsis with acute respiratory failure. A computed tomography scan of the chest without intravenous (IV) contrast on [DATE], indicated Resident C patent of the g-tube does not appear to be within the lumen of the stomach, but appears to be within the wall. It was recommended the g-tube be repositioned and no medications/feedings through the tube until then. Resident C's g-tube was located in the anterior wall of the stomach. A hospital discharge note containing the hospital course summary, dated [DATE], indicated Resident C was admitted from the facility .with several says of increase trach secretions, increased work of breathing, blood around trach, and hemoptysis [bloody sputum] .Patient [Resident C] was admitted to the hospital for septic shock due to pneumonia and peritonitis associated with her g-tube .Her g-tube was removed and replaced by IR [Interventional Radiology] successfully as this was a concern for source of infection . An interview with the DNS, on [DATE] at 1:20 p.m., indicated that it is their standard practice to have the placement of g-tube check at least every shift and prior to anytime it is accessed. Staff are to check placement by checking for residual and this should be documented on the medical record. An interview with LPN 3 on [DATE] at 1:44 p.m., indicated she had taken care of Resident B the morning she was sent to the ER. She indicated usually the resident could nod yes or no, but that was about it, but she was unresponsive that morning. In report, the off going nurse stated her urinary catheter was leaking and Resident B had a rough night, but LPN 3 did not get any other information in report. When asked about the procedure to check placement of a g-tube, she indicated that they should auscultate a 30-cc air bolus and then check for residual. The residual should be documented on the MAR/TAR, but not every resident had the order placed on their MAR/TAR. She indicated if the residual was more than 30 ml then she would hold the feeding and that no residual was an indication of an empty stomach. She did not check the residual of Resident B on the morning of [DATE] due to her change of condition and not being time for medications. An interview with DNS on [DATE] at 2:20 p.m., indicated that the staff would check the placement with residual and that no residual would indicate the resident's body is absorbing the feeding as intended. Indications for a displaced feeding tube would be issues with flushing, leaking, or feeding coming back up in the tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A policy entitled, Enteral Nutrition, was provided by the Administrator on [DATE] at 11:00 a.m. The policy indicated that staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube such as tube misplacement or migration and preformation of the stomach or small intestine leading to peritonitis. A policy from the pharmacy services entitled [Name of Pharmacy], was provided by the DNS on [DATE] at 2:20 p.m. The policy indicated, Assess for gastric residual volume a. Not recommended for resident(s) who are alert and able to report symptoms indicating enteral feeding is not being tolerated well b. Check prior to mediation(s) administration . 36942 3. The clinical record for Resident E was reviewed on [DATE] at 2:00 p.m. The diagnoses included, but was not limited to, gastrostomy status, anoxic brain damage, weakness, tracheostomy status, dysphagia, and dependence of ventilator status. An Admission MDS assessment, dated [DATE], indicated she was comatose and required total assistance with two staff person for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. She had a feeding tube. A care plan for g-tube feedings, revised [DATE], indicated interventions to administer tube feeding and water flushes per physician orders, check for tube placement and gastric contents/residual volume per facility protocol and record, document abnormal findings and notify the physician, and observe for complications such as tube being dislodged. An observation conducted of Resident E, on [DATE] at 12:00 p.m., with a urinary catheter tube present in the abdomen as a temporary feeding tube indicated by the Assistant Director of Nursing Services (ADNS). The ADNS indicated Resident E's feeding tube became dislodged with the balloon still inflated and caused trauma to the opening where the feeding tube entered. This incident occurred on [DATE]. They are waiting to see if the urinary catheter works and then ask for a gastroenterology consult in the case there was excess drainage or other complications that warrant the consult. An anonymous interview conducted during the survey from [DATE] to [DATE], indicated the opening to Resident E's g-tube site is the size of a half dollar and was draining excessive amounts of tube feeding when the tube became dislodged. The dressing was removed during the interview and the dressing was saturated with a brown and black substance with a half dollar size opening to the stoma site. The resident needed the g-tube replaced or a consult with a GI specialist but that hasn't been conducted. When they asked about replacing the feeding tube at the facility the response was where can we get one of those? This was referring to the feeding tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated [DATE] at 1:17 p.m., indicated the following, .nurse was in at 1100 [11:00 a.m.] to flush feed tube and G-tube was out .Physician gave order to replace G-tube with 18F [size of catheter] Foley. ADON [Assistant Director of Nursing] inserted 18F foley without complication. Checked placement via auscultation and checked residual. Patient's feed was restarted with excessive leaking. This nurse notified physician and was given an order to place 22F [larger size catheter] foley catheter. Per physician a small amount of leakage is to be expected until the stoma site begins to close which should happen within a few hours. Physician ordered that facility either order a j-peg to be placed at facility or sent patient to GI [gastroenterology] for new placement, 22F foley is intact, checked residual and auscultation. Feed is currently restarted with minimal drainage. Another progress note, dated [DATE] at 6:35 a.m., indicated the following, .This nurse examined stoma site, I visualized what looks like obvious trauma from G-tube being dislodged completely, stoma looks like it has signs of ripping with excessive leaking, looks to be like it may need suturing. GI [gastrointestional] consult is definitely warranted. Applied moist dressing on stoma site with dried dressing on top, paper tape was used to secure dressing remains patent [sic]. Will require NP [Nurse Practitioner] to assess for further treatment. An observation was conducted of Resident E's care with Certified Nursing Assistant (CNA) 5 and CNA 6 on [DATE] at 11:10 a.m. Both CNA 5 and CNA 6 commented that Resident E cannot move on her own. Her hands were observed to be contracted bilaterally with palm protectors in place. CNA 6 stated she worked on [DATE] and didn't have any concerns regarding Resident E's g-tube and no staff asked her questions regarding Resident E's g-tube. She was not aware Resident E's g-tube became dislodged. An interview conducted with the Director of Nursing Services (DNS), on [DATE] at 1:13 p.m., indicated Resident E does not move. She was unaware of what occurred and lead to the dislodgement of Resident E's g-tube. The site looked traumatized when it first happened. An order was obtained to place a Foley catheter until a PEG tube (feeding tube) placed. They got an order for a 16 Fr (size of Foley catheter) initially but then placed a large sized one because it was leaking initially. The hole would close until the PEG tube can be placed. Resident E came to the facility with the PEG tube in place. The DNS spoke with Licensed Practical Nurse (LPN) 8, who was working the morning of the incident, and asked her to speak to the aides caring for Resident E the morning of the incident. She wanted to know when the aides were in to care for Resident E last and she could hear the aides speaking in the background answering the questions. The aides responded, it was around 10:00 a.m., was when the last time they cared for Resident E before the dislodgement of the g-tube, and it was intact to the best of their knowledge. She doesn't believe Resident E was capable of manipulating the g-tube. She was in a comatose state. A physician order, dated [DATE], for a KUB until g-tube was replaced. A physician order, dated [DATE], was noted to replace feeding tube with a 22 Fr foley catheter until resident can be seen by gastroenterology. This order was not entered until [DATE] but had a start date of [DATE]. An interview conducted with Unit Manager 10, on [DATE] at 11:25 a.m., indicated he investigated Resident E's g-tube being dislodged and couldn't determine the cause of it becoming dislodged. The Nurse Practitioner was here the evening of [DATE] and ordered a KUB to check for placement and if that cannot get completed then possibly send Resident E to the emergency room for replacement of her feeding tube. He was reaching out to schedule a gastroenterology consult for Resident E on [DATE]. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated [DATE] at 2:01 p.m., indicated a KUB was able to be conducted on Resident E related to not having contrast material available. The KUB was discontinued and if residual from g-tube was greater than 150 milliliters then call the Nurse Practitioner and update about the situation involving the KUB not being completed. As of [DATE] at 10:00 a.m., there were no other progress notes in Resident E's clinical record about follow-up with a GI consult or replacing her g-tube from the urinary catheter that was in place at that time. This Federal tag relates to Complaint IN00378410. 3XXX,d+[DATE](a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review, the facility failed to ensure an antibiotic was administered as prescribed for 1 of 5 residents reviewed for a change in condition. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/27/22 at 2:00 p.m. The diagnoses included, but was not limited to, tracheostomy status, gastrostomy status, weakness, diabetes mellitus, and age-related physical debility. Resident D was admitted to the facility on [DATE] and hospitalized on [DATE]. Resident D readmitted to the facility on [DATE]. A discharge medication list, dated 1/10/22, included the following orders: - amoxicillin-clavulanate (Augmentin) 875-125 milligrams; 1 tablet twice daily for 7 days & - doxycycline hyclate 100 milligrams; 1 tablet twice daily for 10 days. A physician order, dated 1/10/22, noted Augmentin tablet 875-125 milligrams and to administer 1 tablet two times a day every 7 days for infection. The electronic medication administration record (EMAR) for January of 2022, had the following date(s) signed off that the Augmentin was administered: 1/11/22 at 9:00 a.m., 1/11/22 at 9:00 p.m., 1/18/22 at 9:00 a.m., 1/18/22 at 9:00 p.m., & 1/25/22 at 9:00 p.m. The order was not inputted for twice daily for 7 days. Resident D only received 5 administrations of Augmentin instead of the 14 doses as ordered from the hospital. A physician order, dated 1/10/22, noted Doxycycline Hyclate 100 milligrams and to administer 1 tablet two times a day every 10 days for infection. The EMAR for January of 2022, had the following date(s) signed off that the Doxycycline was administered: 1/11/22 at 9:00 a.m., (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/11/22 at 9:00 p.m., 1/21/22 at 9:00 a.m., & 1/21/22 at 9:00 p.m. The order was not inputted for twice daily for 10 days. Resident D only received 4 administrations of Doxycycline instead of the 20 doses as ordered from the hospital. An interview with the Director of Nursing Services (DNS), on 4/29/22 at 3:39 p.m., indicated there appeared to be a data entry error related to the antibiotic orders for Resident D. The expectations are for nursing staff to follow the physician orders and/or recommendations from the hospital. This Federal tag relates to Complaint IN00378410. 3.1-25(b)