STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAJESTIC CARE OF AVON	**445 S COUNTY ROAD 525 E AVON, IN 46123**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident call lights were answered in a timely manner, and residents were provided showers, for 8 of 8 residents reviewed for provision of care and resident services (Residents B, C, E, L, M, N, P, and Q). Findings include: Resident Council Minutes, dated 1/14/2020 at 2:35 p.m., indicated showers were not given, ice was not getting passed every shift, and residents stated the CNAs (Certified Nursing Assistant) don't always listen and say they need to do something and never come back. Action taken was in-service. Resident Council Minutes, dated 2/20/22 at 2:58 p.m., indicated CNAs, don't tell the nurse they (residents) need something, residents were told they had to be sleeping at night, residents need longer call light cords, linen was not being changed for those not getting showers, and residents were not getting showers. There was no follow up documentation. Resident Rights reviewed was the right to file grievances. A Concern/Grievance Form, dated 1/14/2020, indicated it was from Resident Council, and residents were not receiving showers. Resolution indicated showers were given. Comments, dated [DATE], indicated residents that stated they weren't receiving showers, received showers. 1. On [DATE] at 2:45 p.m., Resident B was observed lying in bed watching television. She indicated, most days the staff would come into her room and turn off her call light, say they needed to get another staff member to assist with care, or indicated they'd be right back, and never return to take care of her. Management were aware of her concerns, and yet it kept on happening. Average time for call light response was 20 minutes, but certain shifts and dependent on the staff. It could take 2-3 hours for staff to answer the call light. A Concern/Grievance Form, dated 1/6/2020, indicated Resident B had concerns of being changed in a timely manner. Resolution indicated, Staffing requirements. Department Head review and action taken, dated 1/7/2020, indicated resident concerns were addressed. Resident voiced understanding of staffing requirements for toileting and necessity for resident to notify staff if required more than scheduled care. A Concern/Grievance Form, dated 2/13/2020, indicated Resident B was getting only baths 3 times a week, never got a full bed bath. Resolution indicated, the resident was refusing. Department Head review and action taken, dated [DATE], indicated resident refused to get out of bed for showers and had bed baths multiple times a week. When talking with resident she stated her preferences and how she liked to be cleaned up. Record review completed for Resident B on [DATE] at 10:00 a.m., indicated [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) assessment, completed 12/6/19, assessed Resident B's preferences as being somewhat important to choose between a tub bath, shower, or sponge bath. The quarterly MDS assessment, completed on 2/5/2020, assessed Resident B as having the ability to make herself understood and to understand others. BI[CONDITION] (Brief Interview for Mental Status) score of 15 indicated she was cognitively intact. Verbal behaviors and rejection of care were documented 1-3 days during the assessment period. The resident required extensive assistance of 2 or more (+) persons for bed mobility, transfers, toileting, personal hygiene, and total assistance of 2+ persons for the bathing activity. A current ADL (Activity of Daily Living) care plan indicated, Resident B required assistance with bathing and showers due to [MEDICAL CONDITION] and [MEDICAL CONDITION]. 2. During an observation of Resident C on [DATE] at 1:46 p.m., he was sitting in his wheelchair at the bedside, call light was within reach and clipped to the bed. The resident indicated, as of that day he had been upgraded to going to the bathroom independently, but was not yet confident or steady enough to go without staff assistance due to not wanting to fall. Call light response times were approximately a 10 minute wait depending on the staff and time of day. There were times he would have to yell out help me in here to get assistance. On [DATE] at 1:57 p.m., Resident C was observed to turn on his call light, a housekeeper and CNA came to answer at same time, the housekeeper left. The CNA was observed to tell the resident she would have to go check for change in transfer orders, she turned off the call light, and left the room. At 2:06 p.m., Resident C was observed still at bedside in wheelchair and indicated he had not been taken to the bathroom yet. At 2:30 p.m., Resident C indicated, he had been taken to the bathroom about 10 - 15 minutes prior. On [DATE] at 12:05 p.m., Resident C was observed sitting in the doorway to his room, call light activated. There were no CNAs observed on the hallway, and Licensed Practical Nurse (LPN) 7 was at the nurses' desk documenting. At 12:14 p.m., a therapist was observed coming down the hallway propelling another resident, and indicated to Resident C she would be right back. At 12:15 p.m. LPN 7 was observed walking past Resident C as she went down the hallway, she did not acknowledge the resident or his call light. Concern/Grievance Forms, dated January and February 2020, indicated there was no documentation of Resident C's concerns. A record review was completed for Resident C on 3/3/3030 at 3:30 p.m., and indicated [DIAGNOSES REDACTED]. The Admission MDS assessment, completed on [DATE], assessed Resident C as having the ability to make herself understood and to understand others. A BI[CONDITION] score of 15 indicated the resident was cognitively intact. Verbal behaviors occurred 1-3 days during the assessment period. The resident required extensive assistance of 2+ persons for bed mobility, transfers, toileting, personal hygiene, and total assistance of 2+ persons for the bathing activity. 3. On [DATE] at 2:15 p.m., Resident E was observed lying in bed watching television, and scrolling on his cell phone. A strong odor permeated from the room out into the hallway. The resident indicated he had been residing in the facility for several weeks and had not had a shower since admission although he had been told he could have a shower at least twice weekly. He had only received 3 bed baths. He was supposed to be moved into a recliner at bedside for therapy every day, but that had not happened except 2 times when he was actually moved by therapy not nursing. This took away from his allotted therapy time. Resident E indicated, either there was not enough staff or the staff were just not answering call lights. He had just spent 45 minutes with his call light on waiting to be taken off of the bedpan, and part of that time while he was speaking to a therapist. There were daily episodes of the call light not being answered in a timely manner, and it routinely took an average of 30 - 45 minutes for response from the staff. At times he had to physically scream to get care due to hurting. Resident E indicated, he had called the front office on [DATE] at 2:11 p.m. according to his cellphone log, and asked to speak with someone from management, he was mad as he was supposed to have been gotten out of bed after morning huddle and that didn't happen. He had asked to speak to someone about discharge planning and that had yet to happen. On [DATE] at 10:45 a.m., Resident E was observed in recliner at bedside and mechanical lift sitting outside his doorway in the hall. Resident E indicated, after having spoken with the surveyor the prior day, management had come down and agreed upon a plan of getting the resident out of the bed after morning huddle and returning him to bed before the day shift left. There were not enough staff in the evening to get him back into bed before 9:00 p.m. if he got out of bed after lunch. Resident E indicated, the night shift the previous night had been rough and took multiple attempts of calling the facility with his cell phone to get assistance. The resident indicated, his phone log indicated he had called the nurses station on [DATE] at 12:10 a.m., and it took about 28 minutes for nursing to respond and come to his room. A second call at 3:14 a.m., he called and had been told staff would be down, but no one came to his room so he called the facility back at 3:56 a.m., and staff came in at about 4:18 a.m. Resident E indicated, each time he called staff would enter his

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

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) room and turn off the call light, tell him they would be right back, and sometimes they'd come back and sometimes they didn't. Concern/Grievance Forms, dated January and February 2020, indicated there was no documentation of Resident E's concerns. On [DATE] at 11:45 a.m., the Unit Manager (UM) provided a shower binder, and indicated it contained shower sheets dated 2/1/2020 - [DATE]. Resident E had no shower sheets. The shower schedule in the front of the binder indicated, Resident E was to have showers on Monday and Thursday evenings. During an interview on [DATE] at 2:00 p.m., CNA 14 indicated she had been working in the facility for approximately 1 month and worked the evening shift. She was told on 3/4/20 that Resident E was to have a bed bath daily and day shift was to provide the bath. She did not know about his showers. During an interview on [DATE] at 12:05 p.m., the therapist indicated, she worked with Resident E on occupational therapy. Her goal was to have the resident out of bed daily into his recliner, especially because at home he did not have a bed and slept in his recliner. The resident was not transferred out of bed daily. It took 4-5 staff for transfers and it was challenging to gather that many staff together at any given time. The previous afternoon the resident had been asked if he wanted out of bed and he declined, stating it was too late. He did not go into detail about why it would have been too late. During an interview on [DATE] at 3:40 p.m., the DNS indicated, she had not had a lot of interaction with Resident E except for delivering his tray or answering his call light. But she was his CNA Sunday night and Monday. 4. On [DATE] at 10:44 a.m., Resident L was observed lying in bed watching television. The resident indicated she was getting showers, although she had a strong odor of urine that permeated out into the hallway. On [DATE] at 12:02 p.m., Resident L was observed lying on the bed watching television. Strong urine odor could be smelled from the hallway. A Concern/Grievance Form, dated 2/13/2020, indicated, Resident L not receiving showers. Resolution indicated, spoke with daughter about resident refusal. Department Head review and action taken, dated 2/21/2020, indicated spoke with daughter about resident refusing showers. Daughter was aware. They spoke with the resident and convinced her to get a shower. A Concern/Grievance Form, dated 2/13/2020, indicated Resident L was not getting changed. Resolution indicated, educated staff. A record review completed for Resident L on 3/4/3030 at 3:30 p.m., indicated [DIAGNOSES REDACTED]. A Change in Status assessment, completed 2/4/2020, assessed Resident L's preferences as being very important to choose between a tub bath, shower, or sponge bath. On [DATE] at 11:45 a.m., the UM provided a shower binder, and indicated it contained shower sheets, dated 2/1/2020 - [DATE]. Resident L had 3 shower sheet, dated [DATE]20, indicated refused shower, and [DATE] and 2/25/2020 indicated shower was given. The shower schedule in the front of the binder indicated, Resident L was to have showers on Tuesday and Friday evenings. The quarterly MDS assessment, completed on [DATE], assessed Resident L as having the ability to make herself understood and to understand others. A BI[CONDITION] score of 15 indicated the resident was cognitively intact. No signs or symptoms of [MEDICAL CONDITION], behaviors, or rejection of care were documented. The resident required an extensive assistance of 2+ persons for bed mobility, transfers, and toileting. The resident required a 1 person physical assistance in part of the bathing activity. A current care plan for Resident L did not address shower or bathing needs. 5. A Concern/Grievance Form, dated 1/14/2020, indicated Resident M had concern of not receiving showers. Resolution indicated, patient still refusing. Department Head review and action taken, dated on [DATE], indicated resident stated she had not been getting showers, writer asked if she ever refused them and she stated yes. Comments, dated on 1/18/2020, indicated resident continued to refuse showers. She was educated on her shower days and stated would take one on her next scheduled day. A record review completed for Resident M, on 3/4/3030 at 4:00 p.m., indicated [DIAGNOSES REDACTED]. Review of shower documentation in the electronic medical record, dated 2/1/2020 - [DATE], indicated Resident M was documented as having received showers on 2/5, 2/12, 2/15, 2/19, 2/22, 2/26, and 2/29. There was no documentation of refusing showers. On [DATE] at 11:45 a.m., the Unit Manager (UM) provided a shower binder, and indicated it contained shower sheets dated 2/1/2020 - [DATE]. Resident M's 2 shower sheets, dated 2/5/2020 and [DATE]20, indicated the resident received a shower. The shower schedule in the front of the binder indicated, Resident M was to have showers on Wednesday and Saturday during the day. The Significant Change MDS assessment, completed 11/22/19, assessed Resident M as having the ability to make herself understood and to understand others. A BI[CONDITION] score of 15 indicated she was cognitively intact. No signs or symptoms of [MEDICAL CONDITION], behaviors, or rejection of care were documented. She required an extensive assistance of 2+ for bed mobility, transfers, and toilet use. She required total dependence of 1 for the bathing activity. Bathing preference indicated, it was not very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. A current ADL care plan indicated due to stroke required assist with showers. 6. On [DATE] at 11:23 a.m., Resident N was sitting on the side of bed partially dressed. Resident indicated, she was to have a shower that morning and the staff had yet to arrive so she was getting dressed. She was still not receiving showers. Her shower days were to be on Monday and Thursday, but that was not happening, and she had not had a shower for approximately 3 weeks. That morning a CNA had asked if she had a shower, and she was told she'd get one today after breakfast. But the aide had not come back and given her shower. Resident N indicated, the previous Thursday an aide had come in and asked her if she wanted a shower at 10:00 p.m., and she did not take the shower as her long hair would not dry before bed. She felt she was an afterthought and she should have been showered before the end of the staff shift and right before she was ready for bed. It was not hard to do her shower as all staff had to do was set her up and she could do her own. Staff would come in and turn off call lights and would say they'll be back as they have someone else to do that could take 1-1/2 hours, then often not return, maybe they did not have enough staff. Staff should not turn off the call light because they would forget to come back. Staff would turn off her roommate Resident Q's call light and not come back. CNA 16 had come in and turned off Resident Q's call light as it was too close to 10:30 p.m., when evening staff leave, so she was left to be taken care of by the night shift. Night shift would turn roommate on her side and she'd be left in that position all night. Same issues of showers and call lights was brought up every month on Resident Council, but nothing ever gets done. A Concern/Grievance Form, dated 2/20/20, indicated Resident N was not getting showers when others got 3 per week. Resolution forms indicated the unit manager was to pull shower sheets and show resident refusal. Department Head review and action taken, dated [DATE]20, indicated resident was known to refuse showers. UM was to pull shower sheets to show resident refusal. Resident states she often doesn't feel well. On [DATE] at 11:45 a.m., the Unit Manager (UM) provided a shower binder, and indicated it contained shower sheets dated 2/1/2020 - [DATE]. Resident N had 1 shower sheet, dated 2/21/2020, that indicated, refused due to getting a new wrap. The shower schedule in the front of the binder indicated, Resident N was to have showers on Monday and Thursday evenings. During an interview on [DATE] at 2:05 p.m., CNA 15 indicated she had worked in the facility approximately 1 month and worked both day and evening shifts. Resident N and Resident Q were both to be showered on the evening shift. CNA 15 had given Resident Q a bed bath this past week, and she had offered Resident N a choice of shower before or after supper, Resident Q chose to get her shower after supper but then she was not given a shower that evening. Staff knew who to give showers to according to the list in the shower binder. The shower list indicated the resident by room number, the day of the week, and shift to be given. Record review completed for Resident N on 3/4/3030 at 4:30 p.m., indicated [DIAGNOSES REDACTED]. Review of shower documentation in the electronic medical record, dated 2/1/2020 - [DATE], indicated Resident N was documented as having received showers on 2/10, 2/13, and 3/2. There was no documentation of refusing showers. The Significant Change MDS assessment, completed 2/16/2020, assessed Resident N as having the ability to make herself understood and to understand others. A BI[CONDITION] score of 15 indicated she was cognitively intact. No signs or symptoms of [MEDICAL CONDITION], behaviors, or rejection of care were documented. She required supervision of 1 person physical assistance for bed mobility, transfers, and toilet use, and personal hygiene. She required assistance of 1 for the bathing activity. Bathing preference indicated, it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. A current ADL care plan for Resident N, indicated the resident required set up assistance, and bathing of back and hair. The care plan did not address showers. 7. During an observation of Resident P's call light being activated on [DATE] at 10:35 a.m., Licensed Practical Nurse (LPN) 6 entered the room, shut off the call light and immediately exited the room. When interviewed Resident P indicated, she needed assistance because her pants were full of poop. LPN 6 reentered the room and asked the resident what she needed, stating you need out of the bed?, and resident indicated she had dirty pants. During an observation of Resident P on [DATE] at 11:05 a.m. propelling herself down the hallway with feet, the resident indicated LPN 6 had entered her room earlier and shut off the call light without first changing her. Resident P indicated the LPN told her to give me a minute, and left. Resident P indicated, staff coming in and turning off the light without helping them happened more often than could be imagined. Concern/Grievance Forms, dated January and February 2020, indicated there was no documentation of Resident P's concerns. A record review completed for Resident P on 3/4/3030 at 5:00 p.m., indicated [DIAGNOSES REDACTED]. The quarterly MDS assessment, completed on [DATE], assessed Resident P as having the ability to make herself understood and to understand others. A BI[CONDITION] score of 15 indicated the resident was cognitively intact. No signs or symptoms of [MEDICAL CONDITION], behaviors, or rejection of care

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) were documented. The resident required an extensive assistance of 2+ persons for bed mobility, transfers, and toileting, 8. Observation of Resident Q on [DATE] at 11:25 a.m., lying in the bed with the television on. The resident indicated, she had only received 1 shower in the past 3 weeks. Her shower schedule used to be on a Tuesday and Friday rotation, but staff came in and told her they'd changed her to Monday and Thursday. Staff frequently just walked in and turned off her call light and would tell her she must wait on others to be cared for, then they didn't return. Resident Q indicated, there were times she had laid in urine for up to 90 minutes, and staff knew she needed help to turn over. Management had been told of her concerns. Concern/Grievance Forms, dated January and February 2020, indicated there was no documentation of Resident Q's concerns. On [DATE] at 11:45 a.m., the Unit Manager (UM) provided a shower binder, and indicated it contained shower sheets dated 2/1/2020 - [DATE]. Resident Q had 3 shower sheet, dated 2/21/2020 and [DATE]20, that indicated resident had a shower, and [DATE] had a bed bath. The shower schedule in the front of the binder indicated, Resident Q was to have showers on Monday and Wednesday evenings. A record review completed for Resident Q on 3/4/3030 at 5:30 p.m., indicated [DIAGNOSES REDACTED]. The Significant Change MDS assessment, completed 12/16/19, assessed Resident Q as having the ability to make herself understood and to understand others. A BI[CONDITION] score of 15 indicated cognitively intact. No signs or symptoms of [MEDICAL CONDITION], behaviors, or rejection of care were documented. She required an extensive assistance of 2+ for bed mobility, transfers and toilet use. She required physical assistance of 1 person for part of the bathing activity. A Record of In-service, titled, Care Companions, dated [DATE], indicated, Educated staff on responsibilities of care companions paid for by family. Regardless if care companion is present, staff of (facility name) are to perform all care needs for resident including but not limited to incontinence care, linen change, and shower. A Record of In-Service, titled, Kardex/Call lights, dated [DATE]20, indicated, All staff are required to answer call lights. No staff is to turn off a call light until the resident's request has been fulfilled or passed on to an appropriate person (nurse, aide, etc.). During an interview on [DATE] at 12:20 p.m., Registered Nurse (RN) 8 indicated, when the nurses help, the current level of staffing was sufficient, when they didn't help, it was not. There were at least 2 residents in the facility that required several staff, but 20 minutes would be considered an acceptable amount of time for all to finish tasks and go help. She was not able to comment on call light on the night shift or the staff response times. There was enough staff to give showers especially as the UM was out helping them. During an interview on [DATE] at 3:27 p.m., the Director of Nursing Services (DNS) indicated, she was unaware of staff turning off the resident call lights and making them wait for more help. Residents should not have to wait up to an hour for assistance, there were nurses at night that could also help. There was not a policy on leaving the call light on or turning it off upon entering a resident room. The DNS indicated, she would turn off the call light upon entering a resident room, even if she needed to leave to go get assistance as she knew her intention was to not be gone for long, and to return and care for the resident. During an interview on [DATE] at 3:34 p.m., the DNS indicated, the resident shower schedules had been revamped as of the week before as management had noticed there were more showers on one hallway that the other, and they had tried to even them out. After management huddle, every morning and evening around the nurses' station, the Unit Manager (UM) would get on the intercom and sing her shower sheet song, and Certified Nursing Assistants (CNAs) were called to the desk and asked who their showers were for the shift. There was follow up done with the CNAs around 2:00 p.m. to assure the UM had the resident shower sheets, and the same procedure happened for the evening shift. The UM and ADNS (Assistant Director of Nursing Services) helped to give the showers. The DNS indicated, the residents should be getting their showers. The UM was responsible for assuring residents were getting their showers, and CNA's had filled out shower sheets. During an interview on [DATE] at 3:54 p.m., the ED indicated, 2 weeks ago the facility had QA'd (Quality Assurance) the showers and revamped the shower lists. There was an every morning huddle at the nurses' station, and they assured showers were being given. ADL's (Activities of daily living were pulled and audited every morning. The ED indicated, he believed the residents were being given showers. During an interview on [DATE] at 3:58 p.m., the ED indicated the 3rd shift was overstaffed, and they were working on 2nd shift. He indicated, he would pop in to check on call lights in the middle of the night. Department heads would pop in on weekends, and he would randomly ask one of them to come in during middle of the night and not tell anyone else. During the week department heads did magic moment rounds and asked the resident questions about their care. Residents should not have to wait to be taken care of if they required multiple staff, they should be cared for as soon as reasonably possible as staff finish one resident to the next. The ED indicated, there was not a call light tracking system in the facility, on the grievance form when the follow up mentioned call light review it meant the hand written magic rounds responses. On [DATE] at 6:45 p.m., the Executive Director provided an Answering the Call Light procedure, revised 7/18/17, and indicated the policy was the one currently being used by the facility. The policy indicated, The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines .8. Answer the resident's call light as soon as possible .Steps in the Procedure 1. Turn off the light. 2. Identify yourself and call the resident by his/her name .3. Listen to the resident's request. 4. Do what the resident asks of you, if permitted .5. If you have promised the resident you will return with an item or information, do so promptly. 6. If assistance is needed when you enter the room, summon help by using the signal. Documentation. The following should be recorded in the resident's medical record: 1. Requests or complaints made by the resident. 2. How the request or complaint was satisfied . On [DATE] at 6:45 p.m., the Executive Director (ED) provided the Quality of Life-Dignity policy, revision date August 2009, and indicated the policy was the one currently being used by the facility. The policy indicated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .2. (Treated with dignity) means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 3. Residents shall be groomed as they wish and be groomed (hair styles, nails, facial hair, etc.) . The ED indicated, the facility had no policy specific to resident showers. This Federal tag relates to Complaint IN 954. 3.1-3(t) 3.1-(3)(v)(1)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview, and record review, the facility failed to timely report resident to resident abuse within 2 hours, for 3 of 5 residents reviewed of abuse (Residents F, G, and K). Findings include: 1. A report from the Indiana State Department of Health Survey Report System, dated 2/22/2020 at 6:56 p.m., indicated, on 2/21/2020 at 7:01 p.m., Resident G walked by Resident R and touched Resident R's hair. A record review completed for Resident G on [DATE] at 3:30 p.m., indicated there was no documentation in the electronic medical record to indicate a resident to resident altercation had occurred on 2/21/2020 with Resident R. A record review completed for Resident R on [DATE] at 2:00 p.m., indicated there was no documentation in the electronic medical record to indicate a resident to resident altercation had occurred on 2/21/2020 with Resident G. During an interview on [DATE] at 2:45 p.m., Activity Assistant 9 indicated, she had been working on 2/21/2020 and 2/23/2020 and been witness to Resident G initiating unprovoked resident to resident altercations with Resident F and Resident R. On Friday 2/21/2020 Activity Assistant 9 was in the memory care activity room and observed Resident G clenching Resident R's hair with both hands and pulling her hair. Resident R was yelling, twisting, and trying to get away from Resident G. Activity Assistant 9 and Certified Nursing Assistant (CNA) 10 separated the residents, Resident R who had done nothing to instigate the encounter was mad and being very verbal about how unhappy she was with Resident G. Activity Assistant 9 indicated, she had immediately told the nurse on the unit what had happened, and upon being told to do so, had filled out a written statement and placed it under the DNS' (Director of Nursing Services) door. To her knowledge the Memory Care Facilitator had been informed of the incident by the nurse. 2. A report from the Indiana State Department of Health Survey Report System, dated [DATE]20 at 4:21 p.m., indicated, on 2/23/2020 at 4:15 p.m., Resident G made contact with Resident F's face and then held Resident F's arm. Record review completed for Resident G on [DATE] at 3:30 p.m., indicated there was only a late entry documentation in the electronic medical record to indicate a resident to resident altercation had occurred on 2/23/2020 with Resident F. Record review completed for Resident F on [DATE] at 2:15 p.m., indicated there was no documentation in the electronic medical record to indicate a resident to resident altercation had occurred on 2/23/2020 with Resident G. A witness statement, dated 2/23/2020, Activity Assistant 9 documented, While I was in the activity room working on St. Patrick's Day crafts. (Resident G) was trying to walk around (Resident F). (Resident F) started speaking [LANGUAGE]. (Resident G) said, (I cannot understand what you are saying.) Resident G made contact with Resident F's face. I got up from my craft station, ran over, and immediately made sure (Resident F) would not get hurt again. I yelled for help to nurse (LPN 12) and the two CNA's. (I need some help in here.)

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) The nurse and 2 CNAs came running in to help me separate (Residents G and F). We got them separated and nothing else occurred. I notified the ED about the incident and made a statement. (Nurse 12) is writing a report. During an interview on [DATE] at 2:45 p.m., Activity Assistant 9 indicated, on Sunday 2/23/2020 she had been sitting among residents at a table in the memory care activity room and observed Resident G, who liked to walk as she could not focus on crafts, walk around Resident F who was sitting at the end of the table coloring. As Resident G was trying to walk around Resident F, Activity Assistant 9 could hear Resident F, who does not speak English as her first language, started talking. Then Resident G saying, I don't understand what the (F***) you are saying and observed her hit Resident F in the face. The whole incident happened so fast. Activity Assistant 9 indicated, she ran over and grabbed Resident G's wrists as she had hold of Resident F's forearms and would not let go. Activity Assistant 9 yelled for help and CNAs at the nurses' desk came running in and helped to separate the residents. Activity Assistant 9 spoke with the nurse, she wrote up her statement which she dropped off later at the DNS' office, then called the Memory Care Facilitator and gave a verbal statement. To her knowledge the DNS had received the written statements when she arrived to work on Monday. Resident G had been sent out before for behaviors, but since returning had not had any outbursts. Activity Assistant 9 indicated, both physical altercations with Resident G happened so fast she had not been able to prevent them, but she had immediately stopped them. During an interview on [DATE] at 3:03 p.m., the DNS indicated, on Friday 2/21/2020, she was in the facility and had been notified Resident G had been in the activity room walking around and unprovoked had grabbed Resident R's hair. On Sunday 2/23/2020 she had received a call informing her, Resident G had been in the activity room and made contact with Resident F's face and was holding onto her arm. Both episodes were considered to be abuse. The DNS had notified the ED on both occasions when the incidents happened. For incidents of abuse, she was to report the abuse to the ED immediately, and the abuse was to be reported to the Indiana State Department of Health (ISDH) within 24 hours. During an interview on [DATE] at 3:46 p.m., the ED indicated, he had been notified of resident to resident abuse between Residents F, Resident G, and Resident R. When he'd asked staff if there were injuries and was told no, he'd asked staff to investigate and let him know details, and had started the reportable. Once staff report to him there had been a resident to resident incident, he would report to ISDH immediately, within 24 hours. Either the DNS or ED could report the incidents to ISDH. On [DATE] at 6:45 p.m., the Executive Director provided an Abuse Prevention Program policy, revised 2/22/18, and indicated the policy was the one currently being used by the facility. The policy indicated, Our residents have the right to be free from abuse, neglect, misappropriation of property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the residents symptom .When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, DNS (Director of Nursing), or individual designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury. No later than 2 hours if the event is an allegation of abuse or where there is significant injury .), notify the following persons or agencies of such incident: 1. The State licensing/certification agency responsible for surveying/licensing the facility . 3.1-28(c)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure accurate, complete, and timely resident documentation for 3 of 5 residents reviewed for resident abuse documentation (Residents F, G, and K). Findings include: 1. A Report from the Indiana State Department of Health Survey Report System, dated 2/22/2020 at 6:56 p.m., indicated, on 2/21/2020 at 7:01 p.m., Resident G walked by Resident R and touched Resident R's hair. Record review completed for Resident G on [DATE] at 3:30 p.m., indicated the resident [DIAGNOSES REDACTED]. A late entry progress note for Resident G, dated 2/10/2020 at 10:29 a.m., the Memory Care Facilitator indicated, the housekeeper reported the resident was in another resident's bathroom and refused to come out. A late entry progress note for Resident G, dated 2/21/2020 at 11:10 a.m., created on 2/23/2020 at 11:15 a.m., Licensed Practical Nurse (LPN) 11 documented, she had attempted to collect a urinary analysis culture and sensitivity (UA C&S) in and out (I & O) per sterile technique with no void. Oncoming nurse aware and will attempt to collect urine later in the evening. A late entry progress note for Resident G, dated 2/21/2020 at 7:01 p.m. and created on [DATE]20 at 1:59 p.m., the Director of Nursing Services (DNS) documented, it was reported to her that the resident had grabbed another resident's hair. The residents were separated and the nurse took resident to nurse's station. The resident's daughter was notified, and informed resident would be kept on 15 minute checks. A late entry progress note for Resident G, dated 2/21/2020 at 7:02 p.m. and created on [DATE]20 at 2:16 p.m., the DNS documented, the ED was notified of an incident with another resident. A late entry progress note for Resident G, dated 2/21/2020 at 10:02 p.m. and created on [DATE]20 at 3:03 p.m., the DNS documented, nursing staff was unable to collect urine for urinalysis. A late entry progress note for Resident G, dated 2/22/2020 at 1:45 a.m. and created [DATE]20 at 1:50 p.m., the Memory Care Facilitator documented, the resident continues to be on 15 minute checks. Resident came out of her room on her own accord to join in activities. Resident observing and acting per norm with no signs or symptoms of distress. Will continue to observe. A late entry progress note for Resident G, dated 2/22/2020 at 12:04 p.m. and created [DATE]20 at 3:15 p.m., the DNS documented the nursing staff was unable to collect urine for urinalysis. A late entry progress note for Resident G, dated 2/23/2020 at 10:30 a.m. and created [DATE]20 at 1:54 p.m., the Memory Care Facilitator documented the resident was participating in activities. Per activity staff resident was in good spirits, laughing and socializing with other residents. Staff continued to check on the resident. Resident was acting per her norm with no signs or symptoms of psychosocial distress. A late entry progress note for Resident G, dated 2/23/2020 at 3:05 p.m. and created [DATE]20 at 3:07 p.m., the DNS documented the nursing staff was unable to collect urine for urinalysis. A progress note for Resident G, dated 2/23/2020 at 3:41 p.m., LPN 12 indicated activity staff called for help and the writer went to activity room and this resident was found holding another resident right lower arm. Writer helped to take off her hand from the other resident. Activity staff stated, the resident was participating in activities by the table, came to her and said what you're talking about and slapped her face then held her right lower arm. Writer assisted this resident back to her room and placed her on 15 minutes checks. A Psychiatry Progress Note for Resident G, dated 2/25/2020, indicated the resident was seen at staff request due to daytime sleepiness and continued crawling on the floor. Patient continued to have significant confusion and was found to have defecated on the floor that morning. A Behavior Management & Wandering/Elopement Risk form, dated [DATE] - 2/21/2020, indicated there were 6 residents with behaviors during that time. Resident G was documented as refusal of care, self-stimulating, and grabbing hair, there was no specific date or time of the incidents. A Behavior Management & Wandering/Elopement Risk form, dated [DATE]20 - [DATE], indicated there were 2 residents with behaviors during that time. Resident G was documented as grabbing and yelling at staff, there was no specific date or time of the incidents. A care plan for Resident G, dated 2/4/2020, indicated the resident had a history of [REDACTED]. There were no new interventions to reflect on-going behaviors. 2. A record review completed for Resident R on [DATE] at 2:00 p.m., indicated the resident [DIAGNOSES REDACTED]. Progress notes for Resident R, dated 2/21/2020 - [DATE]20, indicated there was no documentation to indicate a resident to resident altercation had occurred on 2/21/2020 with Resident G. A Psychiatry Progress Note, dated 2/25/2020, indicated the resident was seen for reassessment of psychiatric status following recent incident with another resident. Resident was recently accosted by another resident unprovoked. A Witness Statement, dated 2/21/2020, with an illegible signature indicated, While in activity room, I heard (Resident R) yelling. I looked up and saw (Resident G) holding onto (Resident R's) hair. (Resident R) started cursing at (Resident G). Myself and the other CNA ran over to split the two residents apart. I quickly told (Resident R) to stand up and come with me to the other side of the room to separate the two. One CNA walked out of the activity room with (Resident G) so they were separated. (Resident R) then told me what happened. Reported to my nurse and ED. A Witness Statement, dated 2/21/2020, with an illegible signature, indicated, I was notified by facility staff that (Resident G) had grabbed (Resident R's) hair. Residents were separated and I took (Resident R) to her room and completed a head to toe assessment with no injury noted. (Resident G) was taken to nurse's station. (Resident G's) daughter instructed nurse to keep resident in her room. Facility nurse then educated (Resident G's) daughter that staff are unable to isolate residents in rooms. During an interview on [DATE] at 2:45 p.m., Activity Assistant 9 indicated, she had been working on 2/21/2020 and 2/23/2020 and been witness to Resident G initiating unprovoked resident to resident altercations with Resident F and Resident R. On Friday 2/21/2020 Activity Assistant 9 was in the memory care activity room and observed Resident G clenching Resident R's hair with both hands and pulling her hair. Resident R was yelling, twisting, and trying to get away from Resident G. Activity Assistant 9 and Certified Nursing Assistant (CNA) 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAJESTIC CARE OF AVON	**445 S COUNTY ROAD 525 E AVON, IN 46123**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) separated the residents, Resident R who had done nothing to instigate the encounter was mad and being very verbal about how unhappy she was with resident G. Activity Assistant 9 indicated, she had immediately told the nurse on the unit what had happened, and upon being told to do so, had filled out a written statement and placed it under the DNS's (Director of Nursing Services) door. To her knowledge the Memory Care Facilitator had been informed of the incident by the nurse. 3. A report from the Indiana State Department of Health Survey Report System, dated [DATE]20 at 4:21 p.m., indicated, on 2/23/2020 at 4:15 p.m., Resident G made contact with Resident F's face and then held Resident F's arm. A record review completed for Resident F on [DATE] at 2:15 p.m., indicated the resident [DIAGNOSES REDACTED]. A review of Progress Notes for Resident F, dated 2/23/2020 - [DATE]20, indicated there was no documentation to indicate a resident to resident altercation had occurred on 2/23/2020 with Resident G. During an interview on [DATE] at 2:45 p.m., Activity Assistant 9 indicated, on Sunday 2/23/2020 she had been sitting among residents at a table in the memory care activity room and observed Resident G, who liked to walk as she could not focus on crafts, walk around Resident F who was sitting at the end of the table coloring. As Resident G was trying to walk around Resident F, Activity Assistant 9 could hear Resident F, who does not speak English as her first language, start talking, then Resident G saying I don't understand what the (F***) you are saying and observed her to hit Resident F in the face. Activity Assistant 9 indicated, The whole incident happened so fast. She ran over and grabbed Resident G's wrists as she had hold of Resident F's forearms and would not let go. Activity Assistant 9 yelled for help and CNAs at the nurses' desk came running in and helped to separate the residents. Activity Assistant 9 spoke with the nurse, wrote up her statement which she dropped off later at the DNS' office, then called the Memory Care Facilitator and gave a verbal statement. To her knowledge the DNS had gotten the written statements when she arrived to work on Monday. Resident G had been sent out before for behaviors, but since returning had not had any outbursts. Activity Assistant 9 indicated, both physical altercations with Resident G happened so fast she had not been about to prevent them, but she had immediately stopped them. During an interview on [DATE] at 2:40 p.m., LPN 11 indicated, she had worked with Resident G about 4 days before she was sent out for in-house treatment at a neuropsych hospital for a couple of resident to resident incidents. The resident was sweet but unpredictable, displayed sporadic behaviors and staff would not know what was going to trigger the behaviors. Behaviors tended to be more towards evenings, she would seem to be ok, laughing and dancing, then all the sudden lash out. LPN 11 indicated, all the staff could do was 1:1 (one on one) with her. During an interview on [DATE] at 3:03 p.m., the DNS indicated, on Friday 2/21/2020, she was in the facility and had been notified Resident G had been in the activity room walking around and unprovoked had grabbed Resident R's hair. Nurses had been instructed to separate the residents, and do skin assessments. The DNS notified the daughter. On Sunday 2/23/2020 she had received a call informing her, Resident G had been in the activity room and made contact with Resident F's face and was holding onto her arm. The DNS instructed staff to separate the residents, do skin assessments, and assure safety. She then contacted the Memory Care Facilitator and ED. Both episodes were considered to be abuse. Resident G was put on 15 minute checks. Both episodes were considered abuse. Written statements were obtained from the staff. Progress notes in the EMR (electronic medical record) were late entries except for LPN 12 on 2/23/2020. The DNS asked the staff to write written statements regarding the incidents, and she then documented in the progress notes for them as she wanted to make sure she had all the facts straight. During an interview on [DATE] at 3:46 p.m., the ED indicated, he had been notified of resident to resident abuse between Residents F and G, and then Residents G and R. He knew the nursing staff were trying to document more in the behavior tracking book, he could not answer to why some of the residents had no documentation in the Progress Notes regarding the resident to resident altercations. The DNS had been working with nurses on how to document, and how to document in appropriate places, that was probably why there was late documentation. During an interview on [DATE] at 5:00 p.m., the Memory Care Facilitator indicated, Resident G had been admitted to a neuro psych unit soon after being admitted to the facility, and since returning had been more pleasant and quieter. Besides having 1 episode of refusing a shower, there had been no displays of aggression. The Memory Care Facilitator had been notified via phone of Resident G having 2 recent unprovoked incidents over a weekend on 2/21/2020 and 2/23/2020. The ED had made the determination after the 2nd event on Sunday that Resident G needed to be send back out. As there was no medical POA (Power of Attorney) the facility had to wait for a judge to give an emergency detention order and the physician to sign off on the order. Documentation of the incidents, all interventions, and follow up efforts should have been in the progress notes. Notes of events should have been dated and timed when the incidents happened, not placed as late entries and back dated. On [DATE] at 6:45 p.m., the Executive Director provided an Abuse Prevention Program policy, revised 2/22/18, and indicated the policy was the one currently being used by the facility. The policy indicated, Our residents have the right to be free from abuse, neglect, misappropriation of property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the residents symptom .10. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. 3.1-50(a)(1) 3.1-50(a)(3)