STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAJESTIC CARE OF WEST ALLEN	**6050 S CR 800 E 92 FORT WAYNE, IN 46814**

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** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on interview and record review, the facility failed to ensure a residents had the right to post information on social media without interference for 1 of 1 residents reviewed (Resident H). Findings include: On 7/8/20 at 12:35 P.M., Resident H, identified by the facility as interviewable, was interviewed. Resident H indicated he had concerns about the facility's response to a post he had put on his personal Facebook page. He had posted a comment that alleged a nurse, at his previous facility, had stolen his pain medications. He indicated he had posted the nurse's full name but not the facility where the alleged event had occurred. Resident H indicated the DON (Director of Nursing) of this facility, asked him to remove the post. He alleged the DON told him if he didn't remove it, the police could be contacted and a report filed against him. Resident H indicated the DON had previously worked at the other facility where the incident occurred. He alleged the DON and the nurse, named in his post, were friends and that's why he was asked to remove the post from his Facebook page. He removed the post from his Facebook page but believed his first amendment right to free speech had been violated. He indicated he had filed a grievance with the Administrator. On 7/8/20 at 1:15 P.M., the Administrator was interviewed. During the interview, he indicated he was aware of Resident H's concern, had received a written grievance report on 7/7/20 and was investigating the resident's concerns. A copy of the Complaint/Grievance Report and resident's written statement was provided which read: The DON stated that I needed to delete a post I put on Facebook about a staff member at a different facility. The post stated: Beware: (name) stole my pain medications at the last facility I was at. Just a heads up. The resident's statement indicated he had not named the facility but had stated the staff members first and last name. Resident H indicated he felt his first amendment rights were violated and he shouldn't have had to delete his post. He requested an apology from the DON. On 7/8/20 at 1:37 P.M., the DON was interviewed. During the interview, she indicated she was alerted to the Facebook posting by her former employee; the staff member named in the post. The former employee indicated Resident H had posted allegations regarding missing medications. This had concerned her because she had been the DON of the other facility at the time of the alleged incident. She indicated she went and spoke with the resident and asked if he had any concerns with nursing staff and he stated not here. She then asked him if he had posted anything on Facebook. She indicated he became immediately upset with her. He stated he had every right to post on Facebook whatever he wanted and she indicated she had agreed with him. The DON indicated she told the resident it was his right to post on Facebook due to freedom of speech but she was also concerned that the person named in the post could retaliate against him by calling the police and filing a report. She further indicated that if there was more information to share about the allegation, she'd like to know so that she could report this if there was a need for follow up investigations if needed. The DON indicated the resident did not want to share any further information regarding the allegation. She indicated she had asked Resident H to remove the name of the staff member from his Facebook post which he agreed to do. The DON indicated it had not been her intention to deny the resident his right to free speech rather she was concerned about possible retaliation against him on Facebook. She indicated she wanted to make sure the resident knew who and how to report a concern or file a grievance. On 7/8/20 at 2:02 P.M., the Administrator provided a current copy of the facility policy titled Resident Rights which stated the following: You have the right to exercise your rights as a resident of the facility and as a citizen or resident of the United States .You have the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising your rights This Federal tag relates to Complaint IN 119. 3.1-3(a)(1)(2)
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure behavior modifying medications were administered as ordered by the physician for 1 of 1 residents reviewed (Resident C). Findings include: On 7/8/20 at 3:13 P.M., Resident C's record was reviewed. [DIAGNOSES REDACTED]. A Plan of Care, dated 4/25/20 and revised on 6/30/20, indicated Resident C exhibited behavior symptoms which included, but were not limited to, inappropriate sexual advances to others. Interventions included, but were not limited to, administer medications as ordered and provide psychiatric services as ordered. A Psychiatric Progress note, dated 6/10/20, indicated the resident had a history of [REDACTED]. He was prescribed Depo-Testosterone 100 mg/ml (start date unknown) monthly on the 28th for hypersexuality. Social Service Notes indicated the following: -5/11/20 at 8:53 a.m., the IDT (Interdisciplinary Team) reviewed behavior of inappropriate sexual comments. Redirection used. -6/29/20 at 8:48 a.m., the IDT reviewed behavior of inappropriate sexual advances to others, false beliefs/delusions/hallucinations, cursing, and crying/tearfulness exhibited on 6/26/20. -7/7/20 at 9:01 a.m., the IDT reviewed behavior of false beliefs/delusions/hallucinations exhibited on 7/6/20. A physician order, dated 4/27/20 at unknown time, was for Depo-Testosterone Solution 100 mg (milligrams) per ml (milliliters) (Testosterone [MEDICATION NAME]) inject 1 syringe intramuscularly one time a day starting on the 28th and ending on the 28th every month for hypersexuality. Review of MAR's (Medication Administration Record) dated April, May, and June 2020, indicated Depo-Testosterone was not administered on the 28th of each month as ordered. The records did not indicate the medication had been given at any other time. On 7/10/20 at 3:35 P.M., the DON (Director of Nursing) and SSD (Social Services Director) were interviewed. Both indicated they had not been aware that the resident hadn't received his Depo-Testosterone injection every month as ordered. The DON indicated the medication should have been administered as ordered by the physician. This Federal tag relates to Complaint IN 119. 3.1-48(c)(2)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.