STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of South Bend	52654 N Ironwood Rd South Bend, IN 46635

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 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. 34966 Based on interview and record review, the facility failed to report an allegation of resident to resident abuse to local law enforcement within 24 hours as directed by the facility's policy, when 2 residents were allegedly involved in a physical altercation, resulting in forehead bruising to both residents, (Resident B and Resident C). Findings include: On 2/19/24 at 11:35 A.M., Indiana State Department of Heath Survey Report System, Incident Number 346, indicated, on 1/27/24 at 10:40 A.M., it was reported that Resident B made contact with Resident C and hit him in the face in the hallway while waiting to smoke. The residents were immediately separated, head to toe assessments were completed to note reddened areas to the foreheads of both residents. The report indicated the physician, administrator, and family were notified, Resident B was placed on 15 minute safety checks, and the residents would be separated during activities. On 2/19/24 at 1:35 P.M., during an interview with the Administrator, she indicated the incident was not reported to local law enforcement because neither resident sustained serious bodily injury, so did not feel the incident needed to be reported to local law enforcement. The Administrator indicated she did not believe the facility policy directed them to report resident to resident altercations to local law enforcement if there were no serious injuries. The facility abuse policy directed them to notify the local law enforcement if it was a staff to resident incident, not a resident to resident incident. The Administrator indicated local law enforcement couldn't do anything about the incident, so she did not feel they needed to be notified On 2/19/24 at 1:37 P.M., during an interview, the Director of Nursing (DON) indicated local law enforcement was not notified of the incident as there were no serious injuries. She indicated she did not believe the facility policy directed them to report a resident to resident altercation to local law enforcement if there were no serious injuries. On 2/20/23 at 1:30 P.M., Resident B's clinical records were reviewed. Diagnoses included, but were not limited to, bipolar disorder, schizoaffective disorder, anxiety, intermittent explosive disorder, and post-traumatic stress disorder. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B's Progress Note entry by RN 9, dated 1/27/24 at 10:37 A.M., indicated, This resident physical abuse to another resident. This resident grabbed another resident by the coat and head-butted resident in the hallway by the designated smoking area. Residents separated, upon assessment this resident has a 1x1 reddened area to forehead, no c/o [complaints of] HA [headache], Dizziness, or pain. MD [Medical Director], DNS [Director of Nursing Services], ED [Administrator], SS [Social Service Director] notified. Resident B's Progress Note entry by Social Services, dated 1/27/2024 at 3:09 P.M., indicated, SSD met with the resident to determine why the behavior happened. [Resident B] stated the other resident was in his face and yelled at him let's go MotherF***er [Resident B] stated the other resident tried to strangle him and [Resident B] reacted by headbutting him . On 2/20/24 at 1:50, Resident C's clinical records were reviewed. Diagnoses included, but were not limited to, hemiplegia follow a stoke, dementia with behavioral disturbance, anxiety, and chronic obstructive pulmonary disease. Resident C's Progress Note entry by RN 9, dated 1/27/24 at 10:40 A.M., indicated, This resident physical abuse with another resident.[sic] This resident was grabbed by the coat and head-butted by another resident in the hallway by the designated smoking area. Residents separated, upon assessment this resident has a 1x2 red area to forehead, no c/o HA, Dizziness, or pain. MD, DNS, ED, SS notified. Resident C's Progress Note entry by Social Services dated 1/27/2024 at 3:22 P.M., indicated, SSD spoke with [Resident C] regarding the incident. [Resident C] stated he did start the argument and that he regrets his decision. [Resident C] stated he did have his hands on the other resident's neck. [Resident C] stated he apologized and stated he feels safe. He was placed on 15 min safety checks. On 2/19/24 at 2:04 P.M., a policy titled, Abuse Prevention Program, dated 3/22, was provided by the Administrator who indicated it was the facility's current abuse policy. The policy indicated, .Our facility is committed to protecting our resident from abuse by anyone including .other residents .The development of investigative protocols governing resident abuse .resident-to-resident abuse .When an alleged or suspected . case of .abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury) .notify the following persons or agencies of such incident: notify Law Enforcement . This citation relates to Complaint IN00427142. 3.1-28(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34966 Based on interview and record review, the facility failed thoroughly investigate an allegation of resident to resident abuse when 2 residents were allegedly involved in a physical altercation resulting in forehead bruising to both residents, (Resident B and Resident C). Findings include: On 2/19/24 at 11:35 A.M., Indiana State Department of Heath Survey Report System, Incident Number 346, indicated on 1/27/24 at 10:40 A.M., it was reported that Resident B made contact with Resident C and hit him in the face in the hallway while waiting to smoke. The residents were immediately separated, head to toe assessments were completed to note reddened areas to the foreheads of both residents. The report indicated the physician, administrator, and family were notified, Resident B was placed on 15 minute safety checks, and the residents would be separated during activities. 2/19/24 at 1:35 P.M., during an interview with the Administrator, she indicated she felt the facility's investigation was thorough. She indicated there were no staff statements taken because Registered Nurse (RN) 9 documented the incident in the progress notes. The Administrator indicated no resident statements were taken regarding the incident because she was not aware any residents witnessed the incident, and no residents filed grievances about the incident, so they must have felt safe. On 2/19/24 at 1:37 P.M., during an interview, the Director of Nursing indicated she did not interview staff or residents concerning the incident because she didn't think she needed to since there weren't any injuries. The Director of Nursing indicated she did not know if any staff or residents witnessed the incident, but thought the Environmental Service Manager may have been a witness. She did not get a statement from the Environmental Service Manager. On 2/19/24 at 2:35 P.M., during an interview with Registered Nurse 9, she indicated she was working the floor when she was notified by the Environmental Service Manager that there was an altercation with 2 residents who were going out to smoke, so went down to see what was going on. RN 9 indicated she didn't know if there were any witnesses to the incident. She was told that Resident B and Resident C were lining up to go out to smoke when Resident B grabbed Resident C and hit him on the forehead with his own forehead. On 2/20/24 at 10:04 A.M., during an interview with the Environmental Service Manager, she indicated she did not witness the resident to resident incident, but heard yelling and went to investigate. She found Resident B and Resident C yelling at each other in the hall by the smoker's exit door. She indicated there were 2 other residents who where there at the time and witnessed the incident. She indicated she though Resident C had a mark on his head from the altercation and immediately notified RN 9 of the incident. On 2/20/23 at 1:30 P.M., Resident B's clinical records were reviewed. Diagnoses included, but were not limited to, bipolar disorder, schizoaffective disorder, anxiety, intermittent explosive disorder, and post-traumatic stress disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B's Progress Note entry by RN 9, dated 1/27/24 at 10:37 A.M., indicated, This resident physical abuse to another resident. [sic] This resident grabbed another resident by the coat and head-butted resident in the hallway by the designated smoking area. Residents separated, upon assessment this resident has a 1x1 reddened area to forehead, no c/o [complaints of] HA [headache], Dizziness, or pain. MD [Medical Director], DNS [Director of Nursing Services], ED [Administrator], SS [Social Service Director] notified. Resident B's Progress Note entry by Social Services dated 1/27/2024 at 3:09 P.M., indicated, SSD met with the resident to determine why the behavior happened. [Resident B] stated the other resident was in his face and yelled at him let's go MotherF***er [Resident B] stated the other resident tried to strangle him and [Resident B] reacted by headbutting him . On 2/20/24 at 1:50, Resident C's clinical records were reviewed. Diagnoses included, but were not limited to, hemiplegia follow a stoke, dementia with behavioral disturbance, anxiety, and chronic obstructive pulmonary disease. Resident C's Progress Note entry by RN 9, dated 1/27/24 at 10:40 A.M., indicated, This resident physical abuse with another resident. [sic] This resident was grabbed by the coat and head-butted by another resident in the hallway by the designated smoking area. Residents separated, upon assessment this resident has a 1x2 red area to forehead, no c/o HA, Dizziness, or pain. MD, DNS, ED, SS notified. Resident C's Progress Note entry by Social Services dated 1/27/2024 at 3:22 P.M., indicated, SSD spoke with [Resident C] regarding the incident. [Resident C] stated he did start the argument and that he regrets his decision. [Resident C] stated he did have his hands on the other resident's neck. [Resident C] stated he apologized and stated he feels safe. He was placed on 15 min safety checks. On 2/19/24 at 2:04 P.M., a policy titled, Abuse Prevention Program, dated 3/22, was provided by the Administrator who indicated it was the facility's current abuse policy. The policy indicated, .Our facility is committed to protecting our resident from abuse by anyone including .other residents .The development of investigative protocols governing resident abuse .resident-to-resident abuse .an ongoing review and analysis of abuse incidents .To help with identification of incidents of abuse .Abuse - The willful infliction of injury . Should an incident .of resident abuse .be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. The individual conducting the investigation will, . Interview the person(s) reporting the incident; Interview any witnesses to the incident; .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . review all events leading up to the alleged incident This citation relates to Complaint IN00427142 3.1-28(a)