STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155247	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Southport	8549 S Madison Ave Indianapolis, IN 46227

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. 44849 Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the State Survey Agency for 2 of 3 allegations of abuse reviewed. (Resident B, Resident C) Findings include: 1. During an interview on 4/17/24 at 9:05 a.m., the Social Service Director indicated on approximately 4/2/24, Resident B made an abuse allegation that a black, female staff member hit him in the back of the head. The facility was not able to substantiate the allegation. During an interview on 4/18/24 at 1:00 p.m., Resident B indicated a staff member smacked the back of his head after they had an argument. Resident B did not know if the staff was a nurse or CNA (Certified Nursing Aide), was not able to provide a physical description, and was not sure of the date nor time. During an interview on 4/18/24 at 1:55 p.m., the Administrator indicated on 4/1/24, Resident B made an allegation that a staff member hit him. The Administrator indicated the facility investigated the allegation but were not able to substantiate the abuse allegation. The abuse allegation should have been reported to the State Survey Agency but was not. The clinical record for Resident B was reviewed on 4/18/24 at 1:05 p.m. The diagnoses included, but were not limited to, anxiety and depression. A Quarterly MDS (Minimum Data Set) assessment, dated 2/23/24, indicated Resident B was severely cognitively impaired. A progress note, dated 4/1/24 at 4:01 p.m., indicated Resident B reported a staff member hit him. The nurse assessed Resident B. The social worker, Administrator, and DON (Director of Nursing) were notified. On 4/19/24 at 10:15 a.m., the Administrator provided a copy of a document, titled Report a Concern, dated 4/2/24, and indicated the was this was the concern form that was filled out after Resident B made an allegation of abuse. A review of the document indicated the alleged abuse occurred, on 4/1/24 at approximately 4:00 p.m. when a staff member hit Resident B while providing care. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 4/17/24 at 9:05 a.m., the Social Service Director indicated Resident C made an allegation that a staff member was rough while providing care. RN 1 (Registered Nurse) came to morning meeting and reported the allegation to the Social Service Director and the Social Service Director asked RN 1 to get a statement from Resident C and report the allegation to the Administrator. The Administrator spoke to Resident C, but the Social Service Director did not know the details of that conversation. During an interview on 4/18/24 at 1:55 p.m., the Administrator indicated Resident C made an allegation that a staff member did not provide care in a slow and gentle manner on 3/29/24 at approximately 5:00 a.m. Resident C asked the staff member to slow down but the staff member did not listen. The Administrator indicated the facility was not able to substantiate the allegation of abuse. The clinical record for Resident C was reviewed on 4/19/24 at 9:30 a.m. The diagnoses included, but were not limited to, alcohol abuse, altered mental status, and major depression. An Admission MDS assessment, dated 1/6/24, indicated Resident C was cognitively intact. The electronic medical record did not include sufficient documentation to determine the specific details of the abuse allegation that was made by Resident C on 3/29/24. On 4/19/24 at 10:15 a.m., the Administrator provided a copy of a document, titled Report a Concern, dated 3/29/24, and indicated this was the concern form that was filled out after Resident C made an allegation of abuse. A review of the document indicated the alleged abuse occurred, on 3/29/24 at approximately 5:00 a. m. when a staff member continued to provide care in a manner that was too fast and not gentle enough after Resident C asked the staff member to slow down. On 4/17/24 at 3:05 p.m., the Director of Nursing provided a copy of a facility policy, titled Abuse Prevention Program, dated 3/2021, and indicated this was the current policy used by the facility. A review of the policy indicated when an alleged case of abuse is reported, the Administrator or designee will notify the State certification agency responsible for surveying the facility. This citation relates to Complaints IN00432582 and IN00432713. 3.1-28(c)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on observation, interview, and record review, the facility failed to provide care and services for a resident diagnosed with PTSD (Post Traumatic Stress Disorder) for 1 of 3 residents reviewed.(Resident D) Finding includes: During an interview on 4/17/24 at 11:23 a.m. Resident F indicated the facility had a major illegal drug and alcohol problem. Resident D drank alcohol in the facility and supplied other resident with alcohol. Resident F reported this to the Administrator. During an interview on 4/17/24 at 12:06 p.m. Resident G indicated Resident G witnessed Resident D offer alcohol to other residents. Resident G reported this to the Administrator. During an interview on 4/18/24 at 1:55 p.m., the Administrator indicated he was aware of allegations of illegal drug and alcohol use in the facility. He indicated the facility had never caught anyone doing drugs inside the facility. Staff did find a bottle of vodka in Resident D's room. At that time, the Administrator pulled a small clear bottle out of his desk drawer. The bottle was unopened, clear, plastic 200 ml (milliliters) container with a red label of [NAME] premium blend Vodka. During an interview on 4/19/24 at 8:23 a.m., Resident D indicated he brought Vodka into the facility and got drunk. During an interview on 4/19/24 at 8:28 a.m., the Social Service Director indicated Resident D was caught with Vodka and the Vodka was removed from his room. After the Vodka was found, Resident D's independent LOA (leave of absence) was discontinued. An independent LOA is not always based on a resident's BIMS (Brief Interview for Mental Status) score. On 3/1/24, Resident D requested to go to the hospital shortly after he had been drinking in the facility and was having increased hallucinations. The clinical record for Resident D was reviewed on 4/19/24 at 9:40 a.m. The diagnoses included, but were not limited to, schizophrenia, major depression, psychoactive substance abuse, and alcohol dependence. An Admission MDS (Minimum Data Set) assessment, dated 2/8/24, indicated Resident D was moderately cognitively impaired. The diagnoses did not include post-traumatic stress disorder. A psychiatric progress note, dated 2/9/24, indicated Resident D's overall history, symptoms, and current presentation appears consistent with post traumatic stress disorder. Established diagnoses list included, but was not limited to, post-traumatic stress disorder. A Quarterly MDS assessment, dated 3/13/24, did not include the diagnosis of post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident D's clinical record lacked a person-centered care plan for post-traumatic stress disorder. During an interview on 4/22/24 at 9:05 a.m., the Administrator indicated Resident D should have had a person-centered care plan for post-traumatic stress disorder. On 4/17/24 at 9:18 a.m., the Director of Nursing provided a copy of a facility policy, titled Mood and Behavior Management, dated 7/2018, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility to provide interventions that are specific to the resident's individualized needs. 3.1-43(a)(1)