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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155247 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>02/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Majestic Care of Southport |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>8549 S Madison Ave<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>44849</p> <p>Based on interview and record review, the facility failed to protect a resident's right to be free from verbal and physical abuse when a resident cursed at and spit at another resident for 1 of 3 residents reviewed for abuse. (Resident B, Resident C)</p> <p>Findings include:</p> <p>During an interview on 2/17/25 at 9:20 a.m., Resident B indicated, on 1/22/25 or 1/23/25 at approximately 6:30 p.m., Resident B was with other residents waiting to go outside to smoke. Resident C wheeled up to Resident B and called her a b**** and then said Resident B knew what the f*** Resident C was talking about. Resident B got scared and started wheeling back to her room. Resident C wheeled after her. Resident B was afraid Resident C was going to hit her. Resident B got to her room and Resident C continued to yell and curse at her. LPN 2 came and told Resident C to go to the nursing station. Resident D and Resident E wheeled up to Resident B's room to talk to her. A little while after that, Resident B was sitting near her door talking with Resident D and Resident E when Resident C wheeled up again and called Resident B a b**** and told Resident B she was going to break her neck. Then Resident C spit on Resident B. Resident B had been scared since then. At that time, Resident B became tearful and indicated she didn't feel safe, she was afraid of Resident C, and there was nothing preventing Resident C from coming back to her room if Resident C wanted to.</p> <p>During an interview on 2/17/25 at 9:48 a.m., Resident D indicated he saw Resident C in her wheelchair chase after Resident B. Then Resident B was sitting in her wheelchair at her door when Resident C wheeled up and was yelling and cursing. Resident C spit on Resident B's leg.</p> <p>During an interview on 2/17/25 at 9:55 a.m., Resident E indicated he watched Resident C chase Resident B about a month ago. It started in the hallway so Resident B went to her room. A few minutes later, Resident E was in the hallway next to Resident B's room when he watched Resident C spit on Resident B. Resident D was with Resident E when it happened.</p> <p>The clinical record for Resident B was reviewed on 2/17/25 at 10:15 a.m. The diagnoses included, but were not limited to, anxiety, depression, and psychotic disorder.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 12/15/24, indicated Resident B was cognitively intact.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A Progress Note, dated 1/22/25 at 11:05 p.m., indicated Resident B was argumentative with Resident C. Resident B was yelling at Resident C to get away from her. Resident C wheeled past Resident B's room and started yelling at her. Then both residents began yelling at each other. LPN 1 encouraged Resident B to fill out a report.</p> <p>A Progress Note, dated 1/28/25 at 2:57 a.m., Resident B requested the nurse call the Nurse Practitioner to get her medication for nervousness. Resident B was nervous because of the altercation with Resident C last Thursday (1/23/25).</p> <p>The clinical record for Resident C was reviewed on 2/17/25 at 10:55 a.m. The diagnoses included, but were not limited to, schizophrenia, alcohol abuse, psychoactive substance abuse, and dementia.</p> <p>A quarterly MDS assessment, dated 10/30/24, indicated Resident C was moderately cognitively impaired.</p> <p>A Progress Note, dated 1/22/25 at 11:00 p.m., indicated Resident C had become agitated with Resident B. Resident C was very argumentative with Resident B. Resident C was redirected to her room then Resident C came back out into the hallway and started yelling at Resident B and attempted to spit on Resident B. Resident C was redirected to her room.</p> <p>A psychiatric progress note, dated 1/23/25 at 12:00 a.m., indicated staff report Resident C threatened to spit on Resident B with no known provocation.</p> <p>The clinical record for Resident D was reviewed on 2/17/25 at 11:04 a.m. A quarterly MDS assessment, dated 12/24/24, indicated Resident D was cognitively intact.</p> <p>The clinical record for Resident E was reviewed on 2/17/25 at 11:05 a.m. A quarterly MDS assessment, dated 12/16/24, indicated Resident E was cognitively intact.</p> <p>During an interview on 2/17/25 at 11:32 a.m., LPN 1 indicated she heard Resident C call Resident B a b**** and then told Resident B she was going to spit on her. Then Resident C spit at Resident B, but the spit didn't touch Resident B.</p> <p>On 2/17/25 at 8:50 a.m., the Director of Nursing provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 9/6/24, indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to be free from abuse.</p> <p>This citation relates to Complaint IN00452293.</p> <p>3.1-27(a)(1)</p> <p>3.1-27(b)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>44849</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the state health department when a resident cursed at and spit at another resident for 1 of 3 residents reviewed for abuse. (Resident B, Resident C)</p> <p>Findings include:</p> <p>During an interview on 2/17/25 at 9:20 a.m., Resident B indicated, on 1/22/25 or 1/23/25 at approximately 6:30 p.m., Resident C called Resident B a b****. Then Resident C spit on Resident B.</p> <p>The clinical record for Resident C was reviewed on 2/17/25 at 10:55 a.m. The diagnoses included, but were not limited to, schizophrenia, alcohol abuse, psychoactive substance abuse</p> <p>A Progress Note, dated 1/22/25 at 11:00 p.m., indicated Resident C had become agitated with Resident B. Resident C was argumentative with Resident B. Resident C was redirected to her room then Resident C came back into the hallway and started yelling at Resident B and attempted to spit on Resident B. Resident C was again redirected to her room. Director of Nursing notified.</p> <p>During an interview on 2/17/25 at 11:06 a.m., the Administrator indicated he received a phone call from LPN 1 that there had been a verbal altercation between two residents. It should have been reported.</p> <p>During an interview on 2/17/25 at 11:32 a.m., LPN 1 indicated she heard Resident C call Resident B a b****. Then LPN 1 watched Resident C spit at Resident B. If LPN 1 would not have been right there, Resident C would have been able to get to Resident B to spit on her. LPN 1 did not report this until the next day when the Administrator called her. LPN 1 was not sure if anyone else reported this when it happened.</p> <p>During an interview on 2/17/25 at 1:37 p.m., LPN 2 indicated she did not see Resident C spit at Resident B. LPN 2 couldn't remember if LPN 1 told her about Resident C spitting at Resident B. LPN 2 thought she might have reported this to the Administrator and Director of Nursing but wasn't sure.</p> <p>On 2/17/25 at 8:50 a.m., the Director of Nursing provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 9/6/24, and indicated this was the current policy used by the facility. A review of the policy indicated all allegations of abuse must be reported immediately to the Administrator or designee.</p> <p>This Federal tag relates to Complaint IN00452293.</p> <p>3.1-28(c)</p> |   |  |