STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observations, interviews and record review, the facility failed to ensure the secured memory care unit provided person-centered care, supervision, and engaging activities to prevent resident-to-resident altercations and/or accidents. These deficient practices had the potential to affect 30 of 30 residents who resided in the secured memory care unit (Residents L, B, EE, GG, X, M, N, W, FF, and HH). Findings include: During a confidential interview, a visiting family member indicated, there were a lot of residents that wandered on the locked memory care unit. When they came to visit their loved one, they would be interrupted several times by residents who would wander into the room while they visited. It had really bothered their loved one when they first moved in, but they have since gotten used to it. It could be problematic for some other residents and the visitor sometimes heard other residents yelling at their peers to get out. The family member indicated the unit was usually staffed with two aides and a nurse, but they could use more help especially since there were no activities. There needed to be extra sets of eyes to help with supervision. 1. During a confidential interview, Resident L's family member indicated, Resident L had experienced a decline in her cognitive abilities and an increase of verbal and physical aggression against other residents in the previous months which led up to her move to the facility. She didn't like men and had gotten into an argument with one guy at a previous facility, then got into a second altercation with another, where she pushed him, and he fell . Because of that, she was sent to an in-patient psychiatric facility. Shortly after her return, she was transferred from another skilled nursing facility to [NAME] care of [NAME]. The family member was hopeful that it would be a good fit, as he had been told by the Admissions and Marketing Coordinator, the facility had a specialized and secured memory care unit as well as Doctor on site to help with behaviors and could make medication adjustments as needed. They had her in a room right there near the activity room and a lot of people would wander in and out of her room and she would call me and tell me she didn't like it. They tried to put up one of those Velcro stop-signs but she would take it down, and sometimes when it was up it confused her about leaving or going into her own room. Then they talked like they would try to move her to a less busy area, or at the end of the hall farther away from the commotion, but it didn't happen the family member got a call and was told, she had pushed some guy down, made him fall and he got hurt bad. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview, Resident B's family members indicated, he had experienced increased confusion and had a seizure, which resulted in a hospitalization . During his hospital stay, the family realized they could no longer care for him at home and looked for a place for him to go. They were able to find placement at [NAME] Care of [NAME] since they had an open bed in the secured memory care unit. Resident B didn't want to go, but he couldn't go home. He had a hard time adjusting and was very stubborn. He wandered and walked up and down the hallways a lot and would go into other resident's rooms. The night of the accident, he had been really agitated and upset since around dinner, and the girls thought putting him to bed would help but he didn't want to go to bed then. They kept trying to put him back in bed, and that probably made him more mad. He tried to go into another female resident's room and she pushed him. He fell and hit his head really hard, it caused bleeding on the brain and they even tried to drill a hole in his skull to relieve the pressure, but he just never recovered. The family members indicated, we have nothing against that lady she was in Memory care for a reason too, she was confused, and [Resident B] was just so bull-headed. He had been wandering around that unit from day one, so why couldn't they keep him out of that room? During a confidential interview, it was indicated, Resident L had not been at the facility long, she was very particular about her things and her room. She did not like people going into her room. It was hard to keep wandering residents out of her room. When residents went into her room, she would yell at them and cuss at them. It was indicated, it seemed like most of Resident L's behaviors occurred in the evenings, like many other residents who Sundown (a common clinical phenomenon manifested by the increase of confusion/anxiety/aggression and other neuropsychiatric symptoms, usually occurring in the evening or at night). She would turn fast and could be unpredictable. During a confidential interview, it was indicated, Resident L did not like other resident going into her room, it made her mad and she would lash out. She seemed worse in the evenings. She mostly stayed in her room, to keep other residents out, and when she came out of the room, she always asked if she could leave or go home. During an interview on 3/12/24 at 10:30 a.m., Certified Nursing Aide (CNA) 14 indicated she worked the night of the accident but did not witness the fall. She had just walked back onto the unit from break and heard CNA 15 calling out for help and for someone to go and get the nurse. She saw Resident B face down on the floor, there was a lot of blood, and she ran to the other side of the building to get the nurse. CNA 14 indicated there were no activities or other materials for redirection on night shift because most of the residents would be asleep. The activity room door was usually closed and there were no prepared activities to use if needed. During an interview on 3/13/24 at 11:15 a.m., Qualified Medication Aide (QMA) 16 indicated she worked the night of the accident. She had been told during shift report that Resident B seemed more agitated than usual, and the aides had tried to put him to bed. But he refused to stay in bed. He was up and walked around the unit like normal. It was usual for him to wander and try to go into other rooms. At the time of the accident, she had been sitting at the nurse's station, but faced the front door and did not see Resident B behind her when he tried to go into Resident L's room. A sound first alerted her, but then a second sound made her get up and by the time she turned around, Resident B was already on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/24 at 11:27 a.m., CNA 15 indicated she worked the evening of the accident, but did not witness the altercation. She had been in the activity room across the hall from Resident L's room, but her back was to the door because she had to sit with another resident who could not be left alone in the activity room. She heard a loud noise and got up to go see what happened. Resident B was on the floor face down outside of Resident L's room. He was bleeding badly, and Resident L was yelling that he was coming into her room. Before the accident, Resident B had been up because he refused to go to bed, he was agitated and cussed at the staff, he said, F*** you, I'm not F****** going to sleep! CNA 15 indicated it was hard to keep residents in their rooms, and at night even if there were only a few people wandering on the unit, there was nothing to give them to do besides offer a snack and talk to them. The activity room would be closed most of the time, and the cabinets were locked. There were no activity boxes or ideas to help distract or redirect residents for nighttime shifts. On 3/11/24 at 10:15 a.m., Resident B's medical record was reviewed. He was admitted to the facility on [DATE] for long-term care on the secured memory-care unit. He had diagnoses which included, but were not limited to, unspecified dementia, vascular dementia, and a psychotic disorder with delusions due to known physiological condition. A hospital discharge summary, dated 8/15/23, indicated, .he was lying in a Soma enclosure bed due to agitation . On 8/14 trial off Soma bed, patient reluctant to go to [Nursing Home] . 8/15 failed trial off Soma bed, not cooperative, wanting to go home. An IDT Admission/Readmission Review and Care Plan Initiated/Update form, dated 8/22/23, indicated, Resident B had a diagnosis of dementia, a physician's order to reside on a secured dementia unit, and was at risk for elopement. There was no review of his sustained agitated demeanor and the failed trial off a Soma bed. The form lacked documentation or review of any potential or history of psychiatric behaviors. A nursing progress note, dated 8/23/23 at 8:33 a.m., indicated Resident B refused all Activities of Daily Living (ADL) care and was difficult to redirect and .wandering on unit and entering other resident's rooms . He arrived in only a gown and had no belongings or clothes. Staff continued to redirect resident out of rooms. Staff reported he did not sleep well and had been up and attempted to enter resident's rooms last night. A Medical Doctor (MD) progress note, dated 8/30/24 at 3:25 p.m., indicated, .nursing reports wandering and grumpy demeanor. Continues to look for his wife and sometimes thinks another female resident is his wife A MD progress note, dated 9/13/24, indicated Resident B continued with a grumpy demeanor, insomnia, and thought another female resident was his wife. The MD note indicated, .ordered close observation Resident B had care plans which included the following, but were not limited to: A care plan, initiated 8/24/23, which indicated, he exhibited behavior symptoms of wandering in and out of rooms. Interventions for this plan of care included, but were not limited to: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. encourage family involvement but lacked revision to specify what family, when and how to contact, or types of involvement to expect. b. familiarize resident with own belongings and surrounding, although he had no belongings. c. Give the resident as many choices as possible about care and activities, but lacked revision to specify why kind of activities to attempt. A nursing progress note, dated 9/22/23 at 9:21 p.m., indicated Resident B had been wandering on the locked unit when he wandered into another resident's room. They startled one another which resulted in the resident's making contact with each other and Resident B fell on to the floor. Resident B was assessed and had a head injury to the right side of his face with moderate bleeding and he had altered mental status as he was alert but hard to arouse. 911 was called and Resident B was sent out. Corresponding hospital records were obtained and revealed, Resident B was first sent to the closest local hospital where a CT scan (a type of diagnostic medical imaging) showed multiple life-threatening injuries and he was immediately referred for transfer to a level 1 trauma hospital. While waiting for the transfer, he experienced an episode of vomiting and required intubation to protect his airway, (intubation, the placement of a flexible plastic tube into the trachea to maintain an open airway). Upon arrival to the trauma hospital his initial Glasgow Coma Scale was 3 and improved to 7 after pausing sedation (GCS) a score of 8 or less represents severe brain injury) and was found to have sustained the following injuries upon evaluation: An intracranial hematoma (ICH- a collection of blood within the skull), subdural hematoma (SDH- the result of a severe head injury), Parafalcine and tentorial hemorrhage, bilateral hemorrhagic contusions, Subarachnoid hemorrhage (SAH- a life-threatening type of stroke caused by bleeding into the space surrounding the brain), superior right orbit fracture, right maxillary hematosinus with intraorbital small bone fragment just above the optic globe and bilateral maxillary sinus anterior lateral wall nondisplaced fractures. On 3/11/24 at 11:00 a.m., Resident L's medical record was reviewed. She admitted to the facility on [DATE] into the secured memory care unit. She had diagnoses which included, but were not limited to, Vascular dementia with moderate mood disturbances, unspecified dementia, recurrent and moderate major depressive disorder and generalized anxiety. Pre-admission documentation from her previous facility and her in-patient psychiatric hospital stay were reviewed and revealed the following. Nursing progress notes from the previous facility: a. on 7/31/23 at 2:13 p.m., during video surveillance review it was observed that this resident pushed another resident in the dining room in the early morning of 7/30/23 . b. on 7/31/23 at 2:26 p.m., during camera surveillance from over the weekend, this resident was seen trying to block another resident from passing in the dining room on 7/29/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. on 8/10/23 at 1:17 p.m., resident being placed on one on one care due to behaviors d. on 8/10/23 at 1:17 p.m., during video surveillance of another resident's fall that occurred on 8/8/23 at approximately 6:32 a.m., it was observed that this resident had been verbally arguing with the other resident in the hall about 10 minutes prior and were redirected by staff. After being redirected, once staff had exited the hall, this resident went into the other resident's room for approximately 7 minutes. This resident can be seen trying to pull the door closed but experiencing some tension possible from the resident on the other side. This resident walked down the hall and on the other resident can be seen on the ground in the doorway e. on 8/10/23 at 1:28 p.m., .Resident's Power of Attorney (POA) thinks where she is at now triggers her to have more anxiety and aggression because the resident's there seem more out of it and she is not so much out of it for memory, she is just out of her head completely. POA agreed for psychiatric evaluation and she was transferred to in-patient psych. Psychiatric progress notes from her in-patient stay were reviewed and revealed, .the patient has been displaying the following behaviors physical and verbal aggression, increased anxiety and increased aggression over the last 72 hours. On 8/8, patient was observed verbally arguing with another resident for about 10 minutes. After patient was redirected, she went back to the other patients room to continue the argument. It was discovered that this patient pushed the other resident into the wall, which injured him. The patient has been unable to walk, later the patient went to his room and attacked him with the door. He had to get three stitches in his head. The facility attempted to redirect, provided 1:1 and reassure with no success . Suggestions to redirect behaviors: patient enjoys participating in activities. Allow patient her own personal space as needed An IDT Admission/Readmission Review and Care Plan Initiated/Update form, dated 9/11/23, indicated Resident L had a diagnosis of dementia, a physician's order to reside on a secured dementia unit, and was at risk for elopement. There was no review of her previous incidents, behaviors, and psychiatric care. A MD progress note, dated 9/13/23 at 12:25 p.m., indicated, .Resident was being seen as a new admission . patient presented to [in-patient psych] hospital from 8/10-8/18 for physical and verbal aggression, anxiety, agitation, and physical altercation with another resident. Stabilized with addition of Buspar and discontinuation of Aricept and Depakote A social Service progress note, dated 9/23/23 at 8:53 a.m., indicated the Memory Care Facilitator (MCF) met with Resident L to discuss the incident that occurred on 9/22. Resident L stated that he entered her room without her knowledge and it scared her. MCF placed stop signs outside of her door which this appeased resident Resident L's comprehensive care plans were reviewed and lacked revision to include person-centered identification and interventions for her history of verbal and physical aggression towards other residents. Resident L had a comprehensive care plan initiated 9/11/23 which indicated, [Resident L] is newly admitted to the facility. An intervention for this plan of care initiated on 9/11/23 lacked revision and was left blank as follows: Behaviors: (SPECIFY) Behavior Interventions: (SPECIFY). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/24 at 1:30 p.m., the Director of Nursing Services (DNS) indicated, she got a call from Registered Nurse (RN) 13 who told her about Resident B's fall. The laceration and injury looked severe enough to require stiches to the DON advised to call 911 immediately and he was transported to the hospital shortly after. The DON indicated, when she initiated the investigation she realized there were some troubling circumstances which surrounded both newly admitted residents. Resident B had transferred from a local hospital, and the facility had been told he no longer required the Soma bed, however, when the Emergency Medical Technicians (EMT)s dropped him off at the facility, they told her Resident B had been in the Soma bed when they went to get him. When the DON looked further into Resident L's history, she came across a hospital note that she had gotten into altercations with other residents and had been an in-patient psychiatric resident. The DON indicated all new referrals for admission were sent first to the Corporate Intake and given a Green, Yellow, or Red light for admission. Green meant the referrals had been reviewed and were Okay for admission. Yellow meant admission was dependent on the review of and discretion of the facility Interdisciplinary team (IDT), and Red meant No. Both Residents B and L had been Green Light approved and were reviewed with a standard IDT Admission Review and Care Plan Initiation. The DON indicated the Memory Care Facilitator (MCF) at the time of the residents' admissions should have reviewed the records more comprehensively so that person-centered and appropriate interventions/approaches could have been considered. 2. Three additional resident-to-resident altercations which occurred in the secured memory care unit were reviewed and revealed the following. a. Indiana Department of Health incident report indicated, on 10/27/23, Resident EE wandered into Resident GG's room and went into his closet. Resident GG made contact with Resident EE's upper right lip. Resident EE sustained an abrasion to his upper lip. On 3/13/24 at 2:55 p.m., Resident EE's record was reviewed. He had Diagnoses which included, but were not limited to, moderate unspecified dementia with mood disturbance, and other behavioral disturbance. A Wandering/Elopement Risk Assessment, dated 2/22/24, indicated Resident EE was at risk to wander, had a history of wandering, and could propel himself in his wheelchair. A Minimum Data Set (MDS) assessment, dated 2/12/24, indicated Resident EE had the ability to make himself understood. Brief Interview for Mental Status (BIMS) score was a 5/15, which indicated severe cognitive impairment. No behaviors of wandering were coded for the look-back period of review. On 3/13/24 at 2:55 p.m., Resident GG's record was reviewed. He had diagnoses which included, but were not limited to, unspecified dementia with psychotic disturbance. A Wandering/Elopement Risk assessment dated [DATE] indicated, he was at low risk to wander, he was able to propel himself in his wheelchair. A MDS assessment, dated 3/1/24, indicated, Resident GG was usually able to make himself understood. He had a BIMS score of 9/15 which indicated moderate impaired cognition. No behaviors of wandering were coded for the look-back period of review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents EE's and GG's comprehensive care plans were reviewed for memory care and resident-to-resident altercations and revealed identical interventions as follows: A care plan which indicated they benefited from residing on the secured memory care unit for structured and specialized programming and each intervention for diversion and redirection were the same: Daily activity programming, encourage family to bring in photos and items to cue and alert of past roles and lifestyles, keep resident involved in activities and or socialization to divert behaviors, loneliness, sadness, maintain room as homelike as possible, provide activity calendar with reminders of daily events and provide snacks and fluids as tolerated. A care plan for behavioral symptoms of resident-to-resident altercations and each intervention for diversion and redirection were the same: administer medications as ordered, allow resident to vent feelings/needs, approach resident in a calm and friendly manor, assess resident's needs: food thirst, toileting needs, comfort level, body positioning, pain etc. treat as indicated, document behaviors per behavior management program, explain to resident what you are going to do before initiating task, family resident with own belongings and surroundings, maintain a safe environment for resident, Notify MD and psych services for increase in behavioral symptoms, provide resident personal space and remove resident from situation. The residents care plans lacked revision to include person-centered, specialized/meaningful interventions for dementia care services and intrusive wandering. b. Indiana Department of Health incident report indicated, on 11/10/23 Resident X wandered into Resident M's room. He made contact with her right arm and right eye. Resident X sustained a skin tear which measured 1.2 centimeter (cm) long, 0.4 cm wide and 0.1 cm deep. Resident X sustained bruising around her eye described on a skin sheet as dark purple and red, and measured 1.1 cm long and 0.3 cm wide. On 3/13/24 at 2:55 p.m., Resident X's record was reviewed. She had a diagnosis which included, but was not limited to, moderate unspecified dementia with psychotic disturbance. A Wandering/Elopement Risk Assessment, dated 12/7/2023, indicated she was at risk to wander, she had a history of wandering, and was able to propel herself in her wheelchair. A MDS assessment, completed on 2/29/24, assessed the resident as usually making herself understood. BIMS score 1/15 indicated severe cognitive impairment. No signs or symptoms of delirium, behaviors, rejection of care, or wandering. On 3/13/24 at 2:55 p.m., Resident M's record was reviewed. Resident M had diagnoses which included, but were not limited to, unspecified dementia with a mood disturbance, recurrent/moderate major depressive disorder and generalized anxiety. A Wandering/Elopement Risk Assessment, dated 3/7/24, indicated he was at low risk for wandering and was able to propel himself in his wheelchair. A significant change MDS, dated [DATE], indicated Resident M had the ability to make himself understood. He had a BIMS score of 5/15 which indicated he had severe cognitive impairment. No behaviors of wandering were coded for the look-back period of review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents M's and X's comprehensive care plans were reviewed for memory care and resident-to-resident altercations and revealed identical interventions as follows: A care plan which indicated they benefited from residing on the secured memory care unit for structured and specialized programming and each intervention for diversion and redirection were the same: Daily activity programming, encourage family to bring in photos and items to cue and alert of past roles and lifestyles, keep resident involved in activities and or socialization to divert behaviors, loneliness, sadness, maintain room as homelike as possible, provide activity calendar with reminders of daily events and provide snacks and fluids as tolerated. A care plan for behavioral symptoms of resident-to-resident altercations and each intervention for diversion and redirection were the same: administer medications as ordered, allow resident to vent feelings/needs, approach resident in a calm and friendly manor, assess resident's needs: food thirst, toileting needs, comfort level, body positioning, pain etc. treat as indicated, document behaviors per behavior management program, explain to resident what you are going to do before initiating task, family resident with own belongings and surroundings, maintain a safe environment for resident, Notify MD and psych services for increase in behavioral symptoms, provide resident personal space and remove resident from situation. The residents' care plans lacked revision to include person-centered, specialized/meaningful interventions for dementia care services and intrusive wandering. c. Indiana Department of Health incident report indicated, on 2/12/23, staff heard a verbal altercation between two residents and were unable to identify the second resident. Staff immediately responded to the noise and Resident N was found on the floor. Resident N was offered a personalized evening activity. Resident N sustained a laceration to the back of her head. An IDT progress note, dated 2/12/24 at 4:34 p.m., indicated an investigation was completed. The fall was unwitnessed, and staff were unable to confirm if any physical altercation took place. On 3/13/24 at 2:55 p.m., Resident N's record was reviewed. She had diagnoses which included, but were not limited to, Alzheimer's Disease, Schizophrenia, and generalized anxiety disorder. A Wandering/Elopement Risk Assessment, dated 2/14/2024, indicated she was at low risk for wandering. A quarterly MDS, dated [DATE], indicated she was able to make herself understood and her BIMS score was 8/15 which indicated moderate impaired cognition. No behaviors of wandering were coded for the look-back period of review. Resident N's comprehensive care plans were reviewed for memory care and resident-to-resident altercations and revealed identical interventions as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan which indicated they benefited from residing on the secured memory care unit for structured and specialized programming and each intervention for diversion and redirection were the same: Daily activity programming, encourage family to bring in photos and items to cue and alert of past roles and lifestyles, keep resident involved in activities and or socialization to divert behaviors, loneliness, sadness, maintain room as homelike as possible, provide activity calendar with reminders of daily events and provide snacks and fluids as tolerated. A care plan for behavioral symptoms of resident-to-resident altercations and each intervention for diversion and redirection were the same: administer medications as ordered, allow resident to vent feelings/needs, approach resident in a calm and friendly manor, assess resident's needs: food thirst, toileting needs, comfort level, body positioning, pain etc. treat as indicated, document behaviors per behavior management program, explain to resident what you are going to do before initiating task, family resident with own belongings and surroundings, maintain a safe environment for resident, Notify MD and psych services for increase in behavioral symptoms, provide resident personal space and remove resident from situation. Resident N's care plans lacked revision to include person-centered, specialized/meaningful interventions for dementia care services and intrusive wandering. 3. During the survey period, the secured memory care unit was observed on multiple occasions for varying lengths of time for review of dementia care services and life enrichment. The following concerns were observed: Continuous unsafe and unsupervised intrusive wandering by Residents W, FF, and HH. Upon an initial visit to the secured memory care unit (MC) on 3/11/24 from 9:42 a.m. until 10:00 a.m., the following was observed. There were no activities occurring at that time. There was no music and/or other sensory stimulation being provided at that time. QMA 8 was passing medications from a cart and the end of the 300 hall, and two CNAs were busy with private resident care. The Nurse Practitioner (NP) was also on the unit, making clinical rounds. There were several residents seated in chairs at the nurses' station, some ambulated up and down the halls and in and out of the activity room. Residents W, FF, and HH were observed to walk almost in a single file line, one behind the other, up and down the halls and dipped into other residents' rooms if their doors were open. Staff did not appear to notice, and the residents were not redirected. On 3/13/24 from 9:45 a.m., until 11:00 a.m., the following was observed. There was no music and/or other sensory stimulation being provided at that time. No staff were observed at the nurses' station, and an unidentified Resident independently ambulated in and out of the nurses station area. There were approximately 9 unsupervised residents in the activity lounge and Residents W, FF and HH walked up and down the halls. They went in and out of other resident's rooms without awareness or redirection. Resident HH wandered into Resident N's room, and Resident N could be heard and she yelled, Help me! Someone help me! Get her out! CNA 12, who had just come out of another resident's room went to help. Resident N was upset and complained that Resident HH came into her room and tried to steal her lipstick. CNA 12 took Resident HH by the hand and walked her away from Resident N's room. She escorted Resident N to the activity room, but then left to provide resident care. Resident HH left the activity room and continued to wander up and down the halls. On 3/13/24 from 1:10 p.m. until 3:20 p.m., the following was observed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:20 p.m., Resident W wandered in and back out of Resident X's empty room. At 1:27 p.m., Resident W wandered in and out Resident HH's empty room and into the room across the hall where Resident QQ was asleep in her bed. At 1:30 p.m., Resident's FF and HH stood together in Resident Q's empty room. When they walked out, Resident W wandered in, fidgeted with the pillow on Resident Q's bed and then walked out. At 1:33 p.m., Resident W wandered into Resident GG's empty room. She unfolded the blanket back from his bed, picked up his sweatshirt from the bed, played with the sleeve material and draped it over the end of his bed and walked out. At 1:36 p.m., Resident W wandered in and out of Resident X's empty room. At 1:37 p.m., Resident W wandered into DD's room and Residents FF and HH fell in line behind her and wandered into Resident DD's room. Resident FF and HH left the room, and Resident W came out of the room with a magazine in her hand. At 1:40 p.m., Resident W wandered into T's room, opened the bottom of a dresser drawer and rummaged through Resident W's personal items. She left the drawer open and walked out. At 1:42 p.m., Resident W wandered into AA's room who was asleep in her bed. Resident W pushed a button on the P-Tac unit and the turned it off. At 1:43 p.m., Resident W wandered into Resident DD's room, she picked up two more magazines from his dresser and took them out of his room. At 2:24 p.m., Resident W began to push Resident QQ's wheelchair. At 2:29 p.m., Resident W wandered in and back out of Resident NN's room. At 2:39 p.m., Resident W wandered in and out, back and forth between Resident HH and QQ's room. At 2:45 p.m. Resident W entered the activity room where several residents were gathered. Without recognizing personal boundaries, she aimlessly wandered through the crowd of seated and standing residents, often almost bumped into them. When trying to go around the table, she took the handles of NN's wheelchair and attempted to push her out of the way, but the chair was stuck on a cabinet handle and the back of a chair in which a resident was seated. Resident W pushed back and forth several times with enough force to cause the cabinet to knock loudly. This was brought to the attention of staff who were in the activity room, but spoke to each other and did not realize Resident W attempted to move Resident NN out of the way. At 2:51 p.m., Resident HH opened Resident EE's closed bedroom door, then entered his room. She opened Resident EE's closed bathroom door, where Resident EE had just finished using the bathroom. Resident EE left his room and Resident HH went in and used his restroom. At (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:54 p.[TRUNCATED]