STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of McCordsville	7476 W Lane Rd McCordsville, IN 46055

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure two staff members were utilized to transfer a resident from the shower chair for 1 of 4 residents reviewed for accidents. (Resident B)Findings include:The clinical record for Resident B was reviewed on 8/18/25 at 12:17 p.m. Her diagnoses included, but were not limited to, history of left total knee replacement, dementia, mood disorder, and depression. A care plan, created 12/28/23 and revised 2/10/25, indicated she required two-person assistance for transfers due to weakness and combative behaviors, as she would pinch or hit staff in various places such as their arms, stomach, and breast. An intervention, revised 5/23/24, was to provide two staff assistance with a stand-up lift with transfers on and off the shower chair for safety. The 8/10/25 Change of Condition evaluation indicated she had warmth and swelling to her left leg/knee area, and it was painful to touch. Her pain level, on a scale of one to ten, was a five. She needed more assistance with activities of daily living and had a decline in transferring. The 8/13/25 follow up reportable incident and investigative file was provided by the DON (Director of Nursing) on 8/18/25 at 12:20 p.m. The 8/13/25 follow up reportable indicated, on 8/10/25 at 2:01 p.m., Resident B was noted to have swelling and pain to her left leg. An x-ray was taken and indicated an acute oblique distal femur fracture. She was sent to the emergency room for further evaluation, and an investigation was initiated. The follow-up section indicated, Based on investigation findings, injury occurred during transfer. Staff member educated on appropriate transfer. The investigative file included the 8/10/25 x-ray of her left femur. The impressions were an acute displaced distal femur fracture.An interview was conducted with the DON on 8/18/25 at 12:36 p.m. She indicated Resident B had a prosthetic knee and they thought her knee somehow twisted when transferred into the stand- up lift by CNA (Certified Nurse Aide) 2. CNA 2 transferred Resident B several times that day, once from bed into her wheelchair to go to the dining room for breakfast, once from her wheelchair into the shower chair in the shower room, again from the shower chair back into her wheelchair, and from her wheelchair back into bed. Afterwards, she had swelling and pain to her knee. CNA 3 was also present for transfers during the shower. Resident B had dementia and was unable to inform them of what happened. Licensed Practical Nurse (LPN) 4 was the nurse present that day, who assessed Resident B. An interview was conducted with CNA 2 on 8/19/25 at 10:58 a.m. She indicated Resident B required two-person assistance to transfer using the stand-up lift. On 8/10/25, she transferred her in the morning, during her shower, and into bed after the shower. CNA 3 assisted CNA 2 with the transfers by helping to support Resident B while being transferred. Resident B was weak during the morning transfer and then vomited in the dining room during breakfast. She and CNA 3 assisted her into the shower. After returning her to bed, CNA 2 informed LPN 4 that Resident B's left leg did not look the same as her right leg. Resident B did not have the ability to really move herself without assistance. If she were to have fallen, she would have needed assistance to get up. CNA 2 thought Resident B had an accident, but she did not think it happened on her shift. An interview was conducted with LPN 4 on 8/18/25 at 1:34 p.m. She indicated Resident B required two-person assistance to transfer using the stand-up lift. They needed two staff for safety reasons, so one could guide the resident and the other to lift her up, as both maneuvered the resident during the lift. She did not assist with any transfers of Resident B on 8/10/25. She was walking with another resident by the shower room. CNA 2 called her name, so LPN 4 peaked her head into the shower room and saw CNA 2 hooking Resident B up to the stand-up lift by herself. LPN 4 only saw CNA 2 in the shower room at this time. Resident B did not appear to be in pain when she saw her in the shower room. Soon afterwards, CNA 2 requested she come to Resident B's room to look at her left leg. Resident B's left leg was sore, as she flinched back and said ouch, when LPN 4 touched it. She did not know who, if anyone was involved in Resident B's transfer back into bed after the shower. An interview was conducted with CNA 3 on 8/18/25 at 2:04 p.m. She indicated Resident B required two-person assistance to transfer using the stand-up lift. She required two people, because one person had to support the resident, while the other one placed the lift pad underneath her back to put her into the chair. She only assisted with one transfer of Resident B on 8/10/25, at breakfast time, from her wheelchair to the shower chair. She did not assist with transferring Resident B any other time that day. She was not present in the shower room for the transfer from the shower chair into her wheelchair. She stated, I'm sure.The Transfers & Mechanical Lifts policy was provided by the DON on 8/18/25 at 12:20 p.m. It indicated, PROCEDURE.10. Two staff members must be utilized when transferring residents with a mechanical lift.13. Staff members are expected to maintain compliance with safe handling/transfer practices.14. Resident lifting and transferring will be performed