STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415753 and IN00415686. This visit was in conjunction with a Recertification and State Licensure Survey and the investigation of Complaints IN00414945, IN00414477, IN00412401, IN00409697 and IN00409479. Complaint - IN00415753 - No deficiencies related to the allegations are cited. Complaint - IN00415686 - Federal/state deficiencies related to the allegations are cited at F600. Complaint - IN00414945 No deficiencies related to the allegations are cited Complaint - IN00414477 No deficiencies related to the allegations are cited. Complaint - IN00412401 Federal/state deficiencies related to the allegations are cited at F921. Complaint - IN00409697 No deficiencies related to the allegations are cited. Complaint - IN00409479 Federal/state deficiencies related to the allegations are cited at F600 and F755. Survey dates: August 20, 21, 22, 23, 24, 25, 26, 27 & 28, 2023 Facility number: 000124 Provider number: 155219	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests a Post Survey Desk Review**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Blackburn	RN, Regional Nurse Consultant	09/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	AIM number: 100266730 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 7 Medicaid: 73 Other: 8 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 9/14/2023.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents interviewed were free of verbal abuse. (Resident E)	F 0600	**1 What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**	09/30/2023

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	Finding includes: On 8/23/23 at 10:22 A.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but was not limited to: End Stage Renal Disease (ESRD), heart failure, diabetic, dependent on dialysis, respiratory failure-dependant on supplemental oxygen and morbid obesity. A Progress Note, dated 8/5/23 at 2:46 P.M., written by RN 5 indicated the resident had a behavior that morning. The Note indicated the resident had waited awhile for CNA 6 and when she arrived, to the room, the resident had taken her own brief off and had thrown it on the floor. RN 5 talked to the resident concerning her behavior with CNA 6. A Progress Note, dated 8/9/2023 at 2:08 P.M., indicated the Interdisciplinary Team (IDT) met with Resident E's sister regarding the incident on 8/5/23. The sister was informed the incident was reported to the Indiana Department of Health and CNA 6 was suspended pending an investigation. A Facility self-reported incident #321 indicated on 8/6/23 at 2:46 PM, " ...resident reported today 8/7/23 to staff that another staff yelled at her during care yesterday ...." CNA 6 was suspended pending investigation. The follow-up, dated 8/14/23, indicated " ...Facility completed investigation and was unable to collaborate Resident's claim. Education provided to staff. Social Service and psych to continue to follow up with Resident as needed ...." A statement from CNA 6, dated 8/14/23, indicated she had went into the Resident E's room around 8:30 A.M. to care for the resident and asked if she was ready to get up. The resident told her it was		Resident E verbalized she feels safe when interviewed by Social Services on 9-29-23 and continues to reside in the facility. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. Other residents were interviewed by DNS/Designee on 8-8-23 with no concerns voiced. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **Staff educated on Abuse policy by DNS/Designee on** 9-29-23. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **ED/Designee will audit/interview 5 residents weekly X6 months to ensure there are no concerns voiced. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial**	

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	to early, so she moved on to check on others. When she later walked back into resident's room. CNA indicated both residents in the room shouted at her for not answering the call light sooner. The statement indicated she went to the resident who needed help, she had her brief off, stool on her gown and her bed linen had been thrown on the floor. CNA 6 apologized to her for not getting there faster but the problem proceeded to escalate, so she went out of the room and found RN 5. RN 5 went to Resident E's room to de-escalate the situation. A statement from roommate, dated 8/7/23, indicated she heard staff yelling at roommate-Resident E. A statement from RN 5, dated 8/10/23, indicated the aide, assigned to resident, came to get her, indicating the resident was having a behavior. Resident E told RN 5 she had to wait for a while before she could get cleaned up. CNA 6 told RN 5 she was attending other residents. RN 5 stated "...Behavior manifested by the resident included taking her dirty brief and throwing it on the floor and had all other trash scattered all over the floor...." Statement indicated RN 5 talked with resident about the "...unacceptable behavior and the aide cleaned the resident up and the room....." A Care Team Member Corrective Action Form, indicated Resident E reported, allegation of abuse, which occurred on 8/6/23, by CNA 6. This was her first corrective action. The form indicated she would return to work, but will not be on the team to take care of resident again. During an interview, on 8/22/23 at 11:06 A.M., Resident E indicated approximately 2 weeks ago when she had diarrhea, the girls who cleaned her		**compliance has been achieved as determined by the committee.**	

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	up weren't nice. She had tried to clean herself up and they were upset with her and raised their voices at her. It made her feel bad. During an interview, on 8/22/23 at 11:21 A.M., Resident K indicated she witnessed the whole incident and called Resident E's sister. RN 5 and CNA 6 were yelling at Resident E, telling her she made a mess. Resident K indicated the CNA is no longer to provide care for either of them. During an interview, on 8/24/23 at 3:19 P.M., Resident E's sister heard the a staff member yelling at Resident E. She came to the facility, the next day, to talk to the Administrator, but he was out of town. The sister indicated Resident E had diarrhea and had her light on for a couple hours, so the Resident E took the brief off herself. The resident's sister thought there were 2 voices but wasn't sure but could hear yelling from the Resident's Roommate's phone on other side of the room. On 8/23/23 at 10:25 A.M., the Regional Nurse Consultant provided a policy titled, "Abuse Prevention Program", dated 2/2018 and revised on 3/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...Abuse - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse			

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	facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, no that the individual must have intended to inflict injury or harm...." This Federal tag relates to complaint IN00415686. 3.1-27(a)(b)			