STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00383913. Complaint IN00383913 - Substantiated. These deficiencies related to the allegations are cited at F0600 Survey dates: July 11 and 12, 2022 Facility number: 000250 Provider number: 155359 AIM number: 100289980 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 11 Medicaid: 32 Other: 12 Total: 55 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 14, 2022	F 0000		
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,			

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

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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	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; Base on interview and record review the facility failed to ensure a resident was free from abuse for 1 of 5 residents reviewed. (Resident B) Findings include: Resident B's record review began on 7/11/2022 at 11:30 AM. Diagnoses included but were not limited to, schizoaffective disorder depressive type, history of traumatic brain injury, cochlear implant status (for persons with moderated to profound hearing loss), diabetes mellitus, hemiplegia and hemiparesis following cerebrovascular disease (a stroke), dementia with behavioral disturbances, anxiety disorder, and pseudobulbar affect (uncontrollable crying or laughing due to brain injury or neurological condition). A review of Resident B's Quarterly Minimal Data Set (MDS) Assessments, dated 6/21/2022, indicated he had a BIMS (Brief Interview for Mental Status) score of 06, which indicated severely impaired cognition. A review of Resident B's progress noted indicated the following: A Health Status Noted dated 6/25/2022 at 11:00 AM, written by RN (Registered Nurse) 1 indicated the resident became agitated and was" going after" CNA (Certified Nursing Assistant) 2. After the CNA left, the resident was	F 0600	**. Social services assessed for psychosocial distress, none noted. C.N.A identified was immediately removed from the facility. C.N.A. was not to return to the facility whil;e investigation was conducted. 2. All interviewable residents were assessed using the abuse questionnaire, no findings. All non-interviewable residents were assessed per head to assessment per licensed nurse- no findings.3. Staff inserviced on abuse policy and prevention by the Executive Director/Designee starting 7/13/2022. All staff will be educated upon hire and at a minimum annually on the Abuse Prevention Policy 4. QAPI tool Awill be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting**	07/22/2022

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	calm with 1:1 (one to one) attention, a snack and the resident was assisted to bed. An Alert Note dated 6/26/2022 at 01:21 (1:20 AM) was entered by the DON (Director of Nursing). CNA 2 had called the DON and reported Resident B had been agitated and was attempting to go back to their prior room, where now a female resident was residing. CNA 2 indicated Resident B had made contact with her and she had pushed the resident back to prevent Resident B from making contact again. The DON asked CNA 2 to clock out of work and leave the facility due to pending investigation of the incident. An Alert Note dated 6/26/2022 at 14:39 (2:39 PM) entered by the DON, indicated a head to toe assessment was completed with no injuries noted at the time. A Health Status Note dated 6/27/2022 at 05:15 (5:15 AM), entered by RN 3, indicated Resident B had a quiet uneventful night with no problems or complaints. Resident B was up in wheelchair wheeling self up and down the hall quietly and watched TV in the lounge. A Social Service (SS) Note dated 6/7/2022 at 14:11 (2:11 PM), indicated the SS wrote a not to Resident B, because he could not read her lips, to asked how he was doing. Resident B was in a pleasant mood and was smiling. An IDT Note dated 6-27-2022 at 14:33 (2:33 PM), entered by the DON, indicated the team discussed the incident between Resident B and CNA 2. Resident B had shown no latent injuries, no hostility towards or fear of staff at the time. Resident B continued to self-propel around without difficulty.			

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Resident B's Progress Notes indicated they were being seen by Psychiatric Services routinely. A note dated 6-28-2022 indicated severe impairment of cognition and judgement and a GDR (Gradual Dose Reduction) of medications would not be considered due to presense of mood and behavioral disturbances in the last 90 days, and a prior failed GDR.

A Social Service Note dated 6-28-2022 at 14:32 (2:32 PM) indicated due to Resident B's increase in episodes of aggression, no GDR would be attempted at this time.

An IDT Noted dated 6-28-2022 at 14:43 (2:43 PM), entered by the DON, indicated the team discussed the incident between Resident B and CNA 2. Resident B had shown no latent injuries form incident. The investigation continued into the incident and CNA 2 remained off of the work schedule. Resident B continued with daily routine without difficulty but had shown no latent injuries form incident.

A review of the facility's investigations of reportable incidents of abuse which was provided by the Administrator on 7-11-2022 at 10:10 AM. Indicated an investigation was completed for the ind=cident between Resident B and CNA 2. The investigation included statement from witnesses, staff working a the time, the DON and CNA 2. The statements indicated the following:

RN 3's written statement dated, Saturday, June 25 at 11:00 PM, indicated, Resident B had their wheelchair in front of their previous room and CNA 2 in a raised, angry tone pulled them away, saying, "that is not your room anymore." Resident B persisted on going back to the door

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	and CNA 2 became more agitated and angry and hollered, "Get Away". RN 3 indicated she went down the hallway and observed the resident sitting on the floor. RN 3 indicated she instructed CNA 2 to leave the resident alone. RN 3 indicated a few minutes later CNA 2 was screaming for help. RN 3 went to find Resident B in their wheelchair with their arms flailing. CNA 2 was observed to punch Resident B at least 3 times with a closed fist to Resident B's head. CNA 2 was screaming foul language at RN 3, crying, then using more foul language toward RN 3. CNA 2 indicated she was "Getting the "f***" out of here" RN 3 told CNA 2 to calm down, and CNA 2 told RN 3, "No, I will Not!, You didn't help me!" RN 3 further indicated CNA 2 didn't seem to understand Resident B was deaf, had a traumatic brain injury and could not comprehend her request. A statement from LPN 4, dated 6-26-2022, indicated she had heard yelling from the COVID Unit, then heard what sounded like a slap sound, then heard crying and a door close loudly. LPN 4 indicated she ran around the building to the COVID Unit to verify if everyone was OK. CNA 2 stated Resident B had slapped her when she had tried to separate Resident B from the female resident in Resident B's prior room. CNA 2 stated she was calling the DON and going home. A statement from the DON dated 6-25-2022, indicated she had received a phone call from CNA 2, stating Resident B came after her and she pushed them away from herself. The DON then received a phone call from RN 3 stating CNA 2 had hit the Resident. The DON indicated CNA 2 was sent home pending an investigation. A statement from CNA 2, was not dated The copy was not a complete copy as it had cut off words.			

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	The statement indicated on Saturday, June 25, 2022, she had come to work on 3rd shift in the facility's COVID Unit. At approximately 11:00 PM, a female resident pushed the call light. The CNA found Resident B in the room standing over the female resident. Resident B was asked to sit in the wheelchair, removed from the room and the door was closed. Resident B immediately began swinging at her, saying it was their room. CNA 2 indicated she had explained to Resident B, the room was switched due to the hall being turned into (COVID Unit, missing text). CNA 2 indicated a commotion ensued with Resident B pushing the mechanical lift and wheelchair away from the room. CNA 2 indicated her first thought was Resident B was going to kick her because they were mad. CNA 2 indicated she pulled Resident B's wheelchair backwards from behind to take them to their room. Resident B got up from the wheelchair and slammed the chair backwards into her. CNA 2 indicated she called for RN 3. CNA 2 indicated her glasses when flying and she has horrible eye sight but could see Resident B coming towardsher. She indicated she pushed Resident B back so she could find her glasses. She indicated at this point RN 3 was coming down the hallway and Resident B kept trying to come towards her swinging. CNA 2 indicated RN 3 did nothing. When Resident B noticed RN 3, they stepped back and quit trying to hit her. CNA 2 indicated she began yelling at RN 3 and asked why she would leave her alone when Resident B had already been aggressive with her. CNA 2 indicated she gathered her things, called the DON and left. A review of a copy of the facility's Indiana State Department of Health Survey Report System, provided by the Administrator on 7-12-2022 at 10:00 AM. indicated, an incident was reported by			

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	the DON. The incident date was 6/25/2022 and incident time was 11:43 PM. The incident involved Resident B and CNA 2. Description of the incident indicated the resident was agitated and trying to hit a staff member. The staff member was trying to remove themselves and pushed the resident away. The staff member was sent home pending the investigation. The follow up to the investigation was added to the report on 6/29/2022 and indicated the investigation of the incident determined the aide, CNA 2, did make contact with Resident B. The statements were conflicting as the nurse stated there was a punch and the aide stated there was a push away in defense. There were no other witnesses to the event. The resident was unable to state in what form the aide made contact with them. In an Interview on 7-11-2022 at 11:20 AM, the DON indicated staff working during the incident were from Agency and Staff Pool. She indicated CNA 2 worked through the Corporate Staffing Pool. She indicated CNA 2's statement was a photograph taken of the statement written by the CNA, then texted from CNA 2's phone to the DON. The DON then sent the text to be copied and included in the investigation of the incident. In an interview on 7/11/2022 at 12:45 PM, PCA (Patient Care Assistant) 5 indicated she had only worked at the facility for a couple of months, and indicated she was educated on abuse, dementia and resident rights during orientation. She indicated she had never seen a staff abuse a resident, but would stop them, calm them and get them apart and report to the DON or Administrator right away. In an interview on 7/12/2022 at 2:00 PM, the DON indicated the staff were in-serviced after the			

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	6-25-22 incident on abuse and reporting during Huddle Meetings at shift change, She indicated she used the facility's Abuse Policy and questions and answers. A review of CNA 2's employee file, provided by the Administrator on 7/12/2022 at 2:15 PM, indicated CNA 2 had a current CNA license, the orientation form indicated she was educated and received the policy and procedures for Resident Abuse / Elder Justice Act, Resident Rights and Dementia Training. The traning was signed by CNA 2. The Care Team Member Acknowledgement was initialed by CNA 2 and indicated, "I understand Majestic Care's no tolerance policy surrounding abuse, neglect and misappropriation of property" was signed by CNA 2. In an interview on 7-12-2022 at 2:15 PM, the Administrator, indicated it could not be determined if CNA 2 hit or pushed Resident B. He indicated he had talked with Resident B on 3 different days and he could not say if he had been hit or pushed. A review of the current facility policy, non-dated, was provided by the Administrator on 7/11/2022, titled, Abuse Prevention Program, indicated, "...Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms...Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers and staff from other agencies providing services to our residents, family members, resident			

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	representative, legal guardians, surrogates, sponsors, friends, visitors, or any other individual...." This Federal tag relates to complaint IN00383913. 3.1-27(a)(b)			