STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155207	A. BUILDING 00 B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00405006 and IN00405242. Complaint IN00405006 - No deficiencies related to the allegations are cited. Complaint IN00405242 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: April 4, 2023 Facility number: 000114 Provider number: 155207 AIM number: 100266640 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 9 Medicaid: 64 Other: 20 Total: 93 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 6, 2023	F 0000		
F 0742 SS=G Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must			

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

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	ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview and record review, the facility failed to develop and implement an effective behavioral management plan for 1 of 1 residents reviewed. This resulted in a resident to resident altercation (Resident Q, and Resident S) and 3 residents fearing for their safety (Resident U, Resident T, and Resident V). Findings include: On 4/4/23 at 12:04 P.M., Resident Q was observed in the hallway in his wheelchair. He was yelling loudly, wanted to go outside and smoke immediately. At the time, the facility was under a severe weather threat. Going outside was not safe. He continued to yell and hurl insults at staff who tried to explain the danger and he could go out after the storm. He yelled angrily he'd been out in storms before and he was going outside to smoke. He continued to yell and scream profanities at anyone around him including residents and staff. Several staff members stood around him from a distance in the hall across from the dining room where residents were seated for lunch. His behaviors were continuous until 12:23 P.M. when he abruptly stopped yelling. -At 12:25 P.M., the resident was yelling, screaming, and threatening anyone around him. He threatened bodily harm to anyone if they came	F 0742	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. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident Q was transferred to the hospital on April 4, 2023 and has not returned. Behavior care plan will be reviewed and updated upon return from hospital. Resident S, T, U and V were assessed for psychosocial reviews and not	04/19/2023

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	near him. He talked to himself and others not present. -From 12:26 P.M. until 1:00 P.M., the resident continued moving about the hallways with staff always present to remove other residents out of his way and keep them safe. He went up to the front desk where he threw items from a table in front of the desk. He continued to scream, yell and threatened others as he moved through the hallway. He eventually turned and went back down the hallway near the dining room where he continued screaming, yelling profanities, threatening anyone who would come near him and hitting the wall. The police were called, he was removed from the facility at 1:10 P.M. and taken to the hospital for evaluation. On 4/4/23 at 1:10 P.M., Resident Q's record was reviewed. Diagnoses included paranoid schizophrenia, vascular dementia with behavioral disturbance, generalized anxiety disorder, depression, nicotine dependence, and bilateral (both) below knee amputations. The resident admitted to the facility following hospitalization for gangrene of the foot. Prior to hospitalization, the resident had been homeless. He had gone to shelters but had been non-compliant with the rules and asked to leave. He was not taking his medications for his mental disorder and indicated he hadn't needed them. Hospital notes indicated he was "gravely disabled" due to schizophrenia. A quarterly MDS (Minimum Data Set) assessment, dated 3/15/23, indicated the resident had moderately impaired cognition. He indicated moods of feeling down, difficulty sleeping, feeling tired, difficulty concentrating and feelings of moving slowly. He had physical and verbal behaviors towards others 1-3 days and had no		affected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All other residents that had the potential of being affected had psychosocial reviews and were not affected. Audit completed of behavior care plans and no other findings. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Behavior care plan implementation education was completed with facility staff on April 14, 2023. How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put into place: Social Service Director/Designee will monitor behaviors and behavior care plans 5 times weekly for 1 month, then 3 times weekly for 2 months, then weekly for 3 months. Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance. QAPI Committee may modify frequency and duration based on	

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	rejection of care during the assessment period. He required extensive assistance of 1 staff for activities of daily living (ADL). Once up in his wheelchair, he required supervision as he propelled himself throughout the facility. Care plans were as follows: -Initiated 12/22/22: the resident exhibited behavior symptoms of paranoid schizophrenia such as believing he was being poisoned by gas in the vents, throwing items and destroying silverware. He had medication in place to treat the symptoms. The goal was for the resident to demonstrate effective coping skills related to his behaviors. Interventions included: administer medications as ordered and provide the resident with plastic utensils with meals. There was no indication the facilit had attempted identify triggers for his behavior. -Initiated 12/22/22: the resident received psychotropic medication and was at risk for side effects of antipsychotic medication. Interventions included: administer medications as ordered by physician. There was no indication the facility had a plan should the resident refuse medications. -Initiated 12/23/22: the resident had behavior symptoms of refusing care, medications and treatments at times. The goal was for the resident to demonstrate effective coping skills related to his behaviors. Interventions included: administer medications as ordered. there was no indication the facility had tracked possible triggers for his refusal behavior, -Initiated 12/27/22: the resident had behavior symptoms of aggression/agitation by slamming doors, pushing chairs/tables and throwing small		percentage of compliance.	

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	objects at the ground. The goal was for the resident to demonstrate effective coping skills related to his behaviors. Interventions included: Identify behavior triggers (room needing swept, trash needing taken out, tables needing to be washed) and reduce exposure to triggers; offer therapeutic activities such as wiping down tables, cleaning hand rails, changing trash liners/picking up trashbags. There was no indication the facility identified interventions aimed at preventing the behavior. A psychiatric NP (Nurse Practitioner) progress note, dated 1/4/23, indicated Resident Q was prescribed Chlorpromazine (anti-psychotic medication for schizophrenia symptoms of aggression and desire to hurt self or others) 100 mg (milligrams) by mouth at bed time. During the visit, resident was being moved to another room because his roommate complained the resident was messy and left messes everywhere. Once in his new room, the resident was observed going through drawers and dumping stuff on the floor. Staff reported he had agitation with aggression at times due to not being able to go outside and smoke when temperatures were too low. The resident destroyed silverware at meals so was given plastic utensils only. Staff reported the resident had behaviors of yelling, screaming, kicking, pushing, grabbing, abusive language, threatening behavior and rejection of care. He was prescribed an anti-anxiety medication for 14 days to assist him with anxiety and fragile mood as he adjusted to the nursing home. Care plans had not been updated with this information to assist staff in providing behavioral care. A licensed counselor progress note, dated			

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	1/13/23, indicated the resident was seen for a diagnostic evaluation. He was described as very moody and not cooperative with care. He used tobacco, got upset when he could not go outside to smoke when he wanted, didn't like to take showers, called staff derogatory names, threw things when upset, tried to get up on his own (had amputations), tipped his wheelchair, argued with staff, and had been having delusions. He had taken apart a bed because he believed he could fix it, had torn things apart in his room and believed they were broken. He had a long criminal history and history of drug abuse in the past. He'd had multiple stays at homeless shelters but would not follow the rules, would become belligerent, threatening, and wouldn't be allowed back. Additionally, he had stays in multiple nursing homes. The recommendation was to follow up with the resident. The care plan did not address the trigger realted to smoking, calling staff degrogatoty names, argueing, or the resident's delusions. There were no psychiatric services provided in February 2023. A review of Resident Q's MAR (Medication Administration Record) dated February, March, and April 2023 indicated the resident had multiple refusals of medication including Chlorpromazine, prescribed to treat his mental illness. In February and March 2023, the resident refused his medications and accepted only 5 doses of Chlorpromazine each month. For April, he'd accepted 1 dose, given on 4/3/23. A (Late Entry) progress note, dated 2/27/23 at 7:34 p.m., indicated the resident had refused all his medications for 1st and 2nd shift. When the			

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	resident was asked if he was ready for his medications, he yelled at the nurse and stated to leave him alone. He helped himself to coffee at the nurse's station. The coffee was was cold, so he threw the coffee all over the floor. A (Late Entry) progress note, dated 2/28/23 at 10:26 a.m., indicated the NP was notified of the resident refusing medication. There were no new orders. A progress note, dated 3/1/23 at 9:40 p.m., indicated the resident had refused all his medications and stated there was nothing wrong with him. No moods or behaviors were observed according to the documentation. A psychiatric NP progress note, dated 3/8/23, indicated the resident had no change in his mood from prior visits. He appeared comfortable, isolating self in his room. The plan was to start him on an anti-depressant medication for depression and anxiety. The progress note had not indicated the resident was refusing his medications. A behavior monitoring record, dated 3/6 through 4/4/23, indicated the following behaviors: -3/12/23 at 3:14 a.m., the resident had behaviors of yelling, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, abusive language, threatening, and being sexually inappropriate. These physical behaviors were not addressed on the care plan, and had no interventions to calm or prevent recurrance. There was no indication of interventions attempted to calm the behavior. -3/16/23 at multiple times during the day/evening,			

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	he had behaviors of yelling, wandering, abusive language and refusing care. There was no indication of interventions attempted to calm the behavior. -3/23/23 at 1:16 p.m., he was yelling.There was no indication of interventions attempted to calm the behavior. -4/4/23 at 8:21 a.m., the resident had behaviors of yelling, pushing, abusive language, and was threatening. There was no indication of interventions attempted to calm the behavior. An Incident note, dated 3/12/23 at 3:00 a.m., indicated a CNA (Certified Nurse Aide) heard shouting down the hall. When the CNA arrived to the room where the yelling was occurring at, they had been unable to open the room door and gained entry from the adjoining bathroom. The resident was observed sitting in his bed, shouting obscenities at his roommate (Resident S) and threatening to do bodily harm to him. The roommate was on the floor in front of the bathroom door. The resident was told to stop his behavior, but he refused and continued to yell and threaten his roommate. The roommate was moved to another room for his protection. An IDT (Interdisciplinary Team) progress note, dated 3/13/23 at 12:36 p.m., indicated a meeting was held to discuss the resident's interaction with his roommate. The residents were separated and safety ensured. The IDT discussed having psychiatric services assess the resident as he had been refusing medications. Staff were to continue to monitor and observe the resident for behaviors. A progress note, dated 3/13/23 at 3:49 p.m., indicated the psychiatric NP was notified of the			

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	resident's recent behaviors and medication refusals. There were no new orders given. Behaviors that occurred on 3/16/23 throughout the day and evening had no further documentation completed as to cause or interventions used to stop the behaviors. A psychiatric NP progress note, dated 3/23/23 at 1:00 p.m., indicated the NP was notified by the nurse of resident's continued refusal of his psychotropic medications over an extended period of time. Review of progress notes had not indicated any behaviors or expressions of aggression in the time frame of 3/16 to 3/23/23. Staff were to continue to monitor him until her next visit. A licensed counselor progress note, dated 3/24/23, indicated the resident had been refusing all of his medications recently. The therapist met with him to offer support. The plan was to continue with ongoing behavioral health services to offer support and affect regulation. There was no documentation in the progress note to indicate the counselor was aware of the incident on 3/12/23 between the resident and his roommate or the threatening behaviors he had displayed. A progress note, dated 4/4/23 at 8:37 a.m., indicated Resident Q had wheeled himself down the hallway, grabbed a clean linen cart and shoved it down the hallway. The Therapy Director was present and reminded the resident not to shove things. He started yelling, cursing, and was verbally aggressive to her. He continued to propel himself down the hall while staff stayed nearby until he calmed down. On 4/4/23 at 1:48 P.M., Resident T and Resident U,			

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	identified as interviewable by the facility, were interviewed. Both indicated they were afraid of Resident Q due to outbursts occurring over several weeks. Two weeks ago, the resident had the same behaviors of yelling obscenities and throwing things. Resident T and Resident U had rooms in the same hallway as Resident Q. Both indicated they no longer felt safe in the facility. Resident T indicated she had been in the activity room across from the dining room when the resident had acted out. She indicated he had come into the room, had thrown an open bottle of Coke at her and got her clothes wet. She indicated the resident always had behaviors related to wanting to go out and smoke. They indicated they had told the Social Services about their fear, but nothing had been done. On 4/4/23 at 2:00 P.M., Resident V, not identified as interviewable but who had been observed near the front desk when Resident Q had been acting out, indicated they hadn't felt safe in the facility over the last month and wanted to leave. The resident indicated residents had to be moved out of Resident Q's way when he was yelling and screaming. The resident indicated this wasn't fair. He was allowed to disrupt everyone else's plans because he had behaviors when he didn't get "his way". Resident V indicated she had told staff about her fears, but someone just came and made sure she was OK after each behavior. On 4/4/23 at 2:08 P.M., the Social Services Director (SSD) was interviewed. She indicated she had been aware the resident had been refusing his medications but wasn't sure what the facility was allowed to do about it because resident's had the right to refuse medications. The resident's history, prior to admission, indicated he was non-compliant with medications. When			

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	questioned, she indicated she wasn't sure what the resident's triggers were for his behaviors. The resident liked to clean so an intervention had been put into place to give him a spray bottle and rag and encourage him to clean when he's frustrated. She did not know if the psychiatric NP or medical doctor had been notified of his refusal to take his medications to treat his mental disorder. She indicated she was going to talk with staff and gather names of resident's who had witnessed Resident Q's mental crisis and removal by police from the facility and follow up to monitor for any psychosocial distress. During a confidential staff interview, Staff 5 indicated several residents were afraid of Resident Q and his many outbursts. Staff tried to shield other residents from his angry outbursts but residents saw, heard them and it was upsetting for them. On 4/4/23 at 4:10 P.M., the Administrator provided a current copy of the facility policies titled "Mood and Behavior Management" and "Psychotropic Management" which stated the following: -"Mood and Behavior Management: It is the policy of the facility to provide interventions for all residents with behavioral and/or mood indicators that may be problematic or distressing. Residents are provided a supportive environment that is aimed at prevention, relief and/or accommodation of their behavior and/or mood in addition to interventions that are specific to the resident's individualized needs...If the resident is being monitored for the symptom(s), the nursing assistant or designee will document the symptom(s) exhibited, interventions attempted and whether they were effective in POC on TASKS. Any new or worsening mood/and/or behavioral symptoms are documented in a			

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	progress note completed by nursing or social services. The IDT reviews all new or worsening moods and/or behaviors, evaluates the interventions, presents any new interventions that may be applicable, and attempts to determine the underlying cause of the symptoms...." -"Psychotropic Management...All residents who are taking antipsychotic medication (used for behavioral indication) are required to have a behavior monitoring program in place identifying targeted behavioral symptoms being monitored as well as personalized non pharmacologic interventions...." 3.1-43(a)(1)			