STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT WAYNE, IN 46804

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00419445 and IN00419911 Complaint IN00419445-No Federal/State deficiencies related to the allegations are cited. Complaint IN00419911-Federal/State deficiencies related to the allegations are cited at F684, F699, F742, and F745. Survey date: October 27, 2023 Facility number: 000476 Provider number: 155446 AIM number: 100290870 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 3 Medicaid: 69 Other: 18 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Blackburn	RN, Regional Nurse Consultant	11/11/2023

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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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to ensure timely physician notification for 1 of 3 residents reviewed. (Resident B) Findings include: An event reported by the facility to the Indiana Department of Health indicated there was a concern for a resident who had inflicted self-injuries with a razor. In an interview on 10/27/23 at 10:25 AM the Administrator indicated Resident B had self-injured their left arm with a razor. The Administrator indicated they were unaware of how the resident had obtained a razor. Resident B's record was reviewed on 10/27/23 at 10:50 AM. Diagnoses included schizoaffective disorder, bipolar disorder, alcohol dependence, nicotine dependence, major depressive disorder, generalized anxiety disorder, non-Alzheimer's dementia, insomnia, other unspecified behavioral disturbances and impulse disorder. Resident B's current comprehensive Minimum Data Set (MDS) dated 8/8/23 indicated their Basic Interview for Mental Status (BIMS) score was 9 (moderate cognitive impairment). The MDS indicated the resident felt hopeless or depressed, had trouble sleeping, felt tired with minimal energy, felt restless, moved slowly and spoke slowly nearly every day.	F 0684	1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD/NP was notified on 10-17 of occurrence for Res B. No adverse effects noted to resident B. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;** All residents who have attempts of self-harm have the potential to be affected by the alleged deficient practice. A whole house audit of all residents will be completed to assess for self-harm and ensure MD/NP notification is completed if noted by 11-14-23. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff educated by DNS to ensure MD/NP notification is completed at time of occurrence by 11-14-23. An audit will be completed each business day to assess for any need of MD/NP notification X6 months. 4. **How the corrective**	11/14/2023

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	A physician order dated 8/1/23 indicated Resident B could be treated by a Psychiatrist and a Psychologist. Resident B's Level 2 Preadmission Screening and Resident Review (PASRR) dated 12/10/21 indicated the resident had an extensive history of inpatient psychiatric admissions due to elopement, refusing medications and physical aggression. The resident was no longer a candidate for assisted living arrangements due to frequent alcohol intoxication and disruptive behaviors. Resident B required specialized mental health services. Resident B's current care plan focus dated 8/2/23 and revised on 8/16/23 with a goal of psychosocial, mental and behavioral needs being met dated 11/1/23 indicated the resident had a problem of behaviors. Interventions included allowing time for resident to answer questions and verbalize feelings. Other interventions included behaviors and follow Level 2 PASSR recommendations. Resident B's behaviors were not specified. Resident B's Level 2 PASSR recommendations were not specified. Resident B's current care plan focus of schizoaffective disorder, substance use disorder, alcohol abuse and alcohol dependence dated 8/13/23 and a goal date of 11/1/23 indicated the resident had a risk of decreased psychosocial wellbeing. Interventions included mental health services. A progress note dated 10/17/23 indicated Resident B had been evaluated due to the facility nursing staff's report of self-inflicted wounds on the resident's left arm. The writer indicated the nursing staff had reportedly observed Resident		**actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA committee will adjust audits based on findings.	

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	B's self inflicted cuts over the weekend on 10/14/23. Resident B had indicated to the staff their injuries were from scratching. The writer indicated the nursing staff later reported the resident had been eating gloves and placing foreign objects wrapped in gloves inside their body cavities. The writer referred the resident to psychiatric services. There was no documentation of the physician having been notified of Residnet B's self injurous behavior on 10/14/23. A Psychiatry Initial Consult dated 10/18/23 at 11:09 AM indicated Resident B had been evaluated for an initial baseline visit for management of psychotropic medications and psychiatric conditions.The consult indicated Resident B had been admitted to a different long-term care facility on 12/3/21 due to a significant history of alcohol and substance abuse which could not be managed in assisted living facilities. Resident B had no permanent address and no support system. Resident B had exhibited poor insight and poor safety awareness at previous facilities. Resident B had displayed behaviors including rapid mood change, striking nursing staff, disobeying facility rules and elopement at previous facilities. The current facility staff had reported removing 3 razors from Resident B's room. The current facility staff had reported Resident B had been eating non-edible items and had placed cigarettes and soap inside their body cavities. Resident B indicated scratches on their arm was due to having had a fall. The writer had then confirmed the facility staff who had worked the previous weekend had observed Resident B's cuts. In an interview on 10/27/23 at 11:25 AM the Administrator indicated Resident B's self-inflicted injury had occurred on 10/17/23. The			

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	Administrator indicated they were unaware of 3 documentation entries that reflected the event happened on 10/14/23. The Administrator indicated they were made aware of Resident B's self-injury on 10/17/23. RN 4 indicated they were present when the Administrator was made aware of the event of 10/17/23. The Administrator and RN 4 indicated the physician and facility management should have been made aware immediately. The Administrator indicated the facility had been without a full time Social Service Dirctor (SSD) until a month ago. In an interview on 10/27/23 at 12:43 PM Registered Nurse (RN) 4 indicated Resident B did not voice a history of trauma, self-harm or suicidal ideation. RN 4 indicated Resident B is self-isolating and likes to be alone. RN 4 indicated they did not believe self-isolating behavior was a predictor of self-harm. RN 4 indicated a resident who presented with the combination of self-isolation, various mental health diagnoses, no family support, addiction and aggressive behavior would benefit from receiving psychiatric services. RN 4 indicated the facility had been trying to transfer Resident B to a more appropriate environment, but choices were limited due to the resident's age. In an interview on 10/27/23 at 12:53 PM the SSD indicated they had not been employed at the facility when Resident B was admitted. The SSD indicated all residents should be assessed for trauma upon admission. The SSD indicated the resident should have been receiving mental health services since the time of admission. The Facility Assessment dated 5/23 indicated the facility would manage the care of individuals with depression, trauma, post-traumatic stress			

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	disorder, (PTSD) and other psychiatric diagnoses. The Facility Assessment indicated the facility would identify hazards and risks for residents. This citation is related to complaint IN00419911. 3.1-37			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review the facility failed to ensure the recognition provision of trauma informed care for 1 of # 3 residents reviewed. (Resident B) Findings include: An event reported by the facility to the Indiana Department of Health indicated there was a concern for a resident who had inflicted self-injuries with a razor. Resident B's record was reviewed on 10/27/23 at 10:50 AM. Diagnoses included schizoaffective disorder, bipolar disorder, alcohol dependence, nicotine dependence, major depressive disorder, generalized anxiety disorder, non-Alzheimer's dementia, insomnia, other unspecified behavioral disturbances and impulse disorder.	F 0699	1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B assessed for trauma. 2 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;** All residents who have a history of trauma have the potential to be affected by the alleged deficient practice. All residents will be assessed for trauma by 11-14-23. 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	11/14/2023

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	Resident B's current comprehensive Minimum Data Set (MDS) dated 8/8/23 indicated their Basic Interview for Mental Status (BIMS) score was 9 (moderate cognitive impairment). The MDS indicated the resident felt hopeless or depressed, had trouble sleeping, felt tired with minimal energy, felt restless, moved slowly and spoke slowly nearly every day. Resident B's Level 2 Preadmission Screening and Resident Review (PASRR) dated 12/10/21 indicated the resident had an extensive history of inpatient psychiatric admissions due to elopement, refusing medications and physical aggression. The resident was no longer a candidate for assisted living arrangements due to frequent alcohol intoxication and disruptive behaviors. A progress note dated 10/17/23 indicated Resident B had been evaluated by the Nurse Practitioner due to the facility nursing staff's report of self-inflicted wounds on the resident's left arm. The Writer indicated the nursing staff had reportedly observed Resident B's self- injuries over the weekend on 10/14/23. Resident B had indicated their injuries were from scratching. The writer indicated the nursing staff later reported the resident had been eating gloves and placing foreign objects wrapped in gloves inside their body cavities. A Psychiatry Initial Consult dated 10/18/23 at 11:09 AM indicated Resident B had been evaluated for an initial baseline visit for management of psychotropic medications and psychiatric conditions. The consult indicated Resident B had been admitted to a long-term care facility on 12/3/21 due to a significant history of		**practice does not recur;** Social Service Director in-serviced by corporate Social Service regarding trauma informed care by 11-14-23. Social Service Director will audit each new admission moving forward to ensure trauma is assessed at admission X6 months. 4 **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA committee will adjust audits based on findings	

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	alcohol and substance abuse which could not be managed in assisted living facilities. Resident B had no permanent address and no support system. Resident B had exhibited poor insight and poor safety awareness at previous facilities. Resident B had displayed behaviors including rapid mood change, striking nursing staff, disobeying facility rules and elopement at previous facilities. The current facility staff had reported removing 3 razors from Resident B's room. The current facility staff had reported Resident B had been eating non-edible items and had placed cigarettes and soap inside their body cavities. Resident B indicated they had scratches due to having had a fall. The writer indicated staff had observed Resident B cutting themselves with a razor. A Social Service History Initial Review dated 10/9/23 indicated Resident B had memories of a difficult early childhood. The review indicated Resident B did not have any family support and her parents' names were unknown. The review indicated Resident B indicated they did not want to discuss past traumatic events that had continued to impact their life. Resident B's current care plan focus of being newly admitted to the facility with a goal of psychosocial, mental and behavioral needs being met dated 11/1/23 indicated the resident had a problem of behaviors. Interventions included allowing time for resident to answer questions and verbalize feelings. Other interventions included behaviors and to follow Level 2 PASSR recommendations. Resident B's behaviors were not specified. Resident B's Level 2 PASSR recommendations were not specified. In an interview on 10/27/23 at 12:43 PM Registered			

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	Nurse (RN) 4 indicated Resident B did not voice a history of trauma. RN 4 indicated Resident B was self-isolating and liked to be alone. RN 4 indicated they did not believe self-isolating behavior meant the resident had a history of trauma. RN 4 indicated the combination of self-isolation, various mental health diagnoses, no family support, addiction and aggressive behavior could be signs of a traumatic history. RN 4 indicated the facility had been trying to transfer Resident B to a more appropriate environment, but choices were limited due to the resident's age. In an interview on 10/27/23 at 12:53 PM the Social Service Director (SSD) indicated they had not been employed at the facility when Resident B was admitted. The SSD indicated all residents should be assessed for trauma upon admission. A current policy dated 3/2019 provided by the DON indicated the facility would implement universal trauma screenings for all residents. The Facility Assessment dated 5/23 indicated the facility would manage the care of individuals with depression, trauma, post-traumatic stress disorder, (PTSD) and other psychiatric diagnoses. The Facility Assessment indicated the facility would identify hazards and risks for residents. This citation is related to complaint IN00419911.			
F 0742 SS=D 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 ensure that- §483.40(b)(1) A resident who displays or is diagnosed with			

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	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 interview and record review the facility failed to assess and track behavior for 1 of 3 residents reviewed. (Resident B) Findings include: An event reported by the facility to the Indiana Department of Health indicated there was a concern for a resident who had inflicted self-injuries with a razor. In an interview on 10/27/23 at 10:25 AM the Administrator indicated Resident B had self-injured their left arm with a razor. The Administrator indicated they were unaware of how the resident had obtained a razor. Resident B's record was reviewed on 10/27/23 at 10:50 AM. Diagnoses included schizoaffective disorder, bipolar disorder, alcohol dependence, nicotine dependence, major depressive disorder, generalized anxiety disorder, non-Alzheimer's dementia, insomnia, other unspecified behavioral disturbances and impulse disorder. Resident B's current comprehensive Minimum Data Set (MDS) dated 8/8/23 indicated their Basic Interview for Mental Status (BIMS) score was 9 (moderate cognitive impairment). The MDS indicated the resident felt hopeless or depressed, had trouble sleeping, felt tired with minimal energy, felt restless, moved slowly and spoke	F 0742	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The facility is unable to correct the alleged deficient practice for Resident B. Resident B's behaviors will be tracked moving forward. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;** All residents who have behaviors have the potential to be affected by the alleged deficient practice. An audit of all residents will be completed by Social Service Director by 11-14-23 to initiate behavior tracking. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Social Service Director in-service by corporate SSD on behavior tracking by 11-14-23. All residents with behaviors will be tracked each business day to	11/14/2023

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	slowly nearly every day. A physician order dated 8/1/23 indicated Resident B could be treated by a Psychiatrist and a Psychologist. Resident B's Level 2 Preadmission Screening and Resident Review (PASRR) dated 12/10/21 indicated the resident had an extensive history of inpatient psychiatric admissions due to elopement, refusing medications and physical aggression. The resident was no longer a candidate for assisted living arrangements due to frequent alcohol intoxication and disruptive behaviors. Resident B required specialized mental health services. Resident B's current care plan focus with a goal of psychosocial, mental and behavioral needs being met dated 11/1/23 indicated the resident had a problem of behaviors. Interventions included allowing time for resident to answer questions and verbalize feelings. Other interventions included behaviors and to follow Level 2 PASSR recommendations. Resident B's behaviors were not specified. Resident B's Level 2 PASSR recommendations were not specified. There was no triggering events identified. A progress note dated 10/1/23 at 11:54 PM indicated Resident B had been pacing and peeking into other resident's rooms. A progress note dated 10/19/23 at 11:08 AM indicated Resident B had been wandering, rummaging through cabinets and nurse station drawers and Lysol had been found in rooms. A progress note dated 10/19/23 at 1:41 PM indicated Resident B had been wandering, talking		ensure appropriate follow up is completed X6 months. **4 How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA committee will adjust audits based on findings.	

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	to a wall hanging and laughing. A progress note dated 10/17/23 indicated Resident B had been evaluated due to the facility nursing staff's report of self-inflicted wounds on the resident's left arm. The Writer indicated the nursing staff had reportedly observed Resident B's wounds over the weekend on 10/14/23. Resident B had indicated their injuries were from scratching. The writer indicated the nursing staff later reported the resident had been eating gloves and placing foreign objects wrapped in gloves inside their body cavities. There was no indication on behavior tracking of the self injurous behavior or of the PICA. A Psychiatry Initial Consult dated 10/18/23 at 11:09 AM indicated Resident B had been evaluated for an initial baseline visit for management of psychotropic medications and psychiatric conditions. The consult indicated Resident B had been admitted to a long-term care facility on 12/3/21 due to a significant history of alcohol and substance abuse which could not be managed in assisted living facilities. Resident B had no permanent address and no support system. Resident B had exhibited poor insight and poor safety awareness at previous facilities. Resident B had displayed behaviors including rapid mood change, striking nursing staff, disobeying facility rules and elopement at previous facilities. The current facility staff had reported removing 3 razors from Resident B's room. The current facility staff had reported Resident B had been eating non-edible items and had placed cigarettes and soap inside their body cavities. Resident B indicated they had scratches due to having had a fall. The writer had then confirmed the facility staff had observed Resident B cutting themselves with a razor.			

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	A Social Service History Initial Review dated 10/9/23 indicated Resident B had memories of a difficult early childhood. The review indicated Resident B did not have any family support and her parents' names were unknown. The review indicated Resident B indicated they did not want to discuss past traumatic events that had continued to impact their life. Resident B's behavior monitor dated 9/28/23 through 10/26/23 indicated the resident had displayed wandering and grabbing behaviors. The behavior monitor did not include the resident's behaviors of rummaging, talking to inanimate objects, talking to themselves, injuring themselves or taking items that do not belong to them. There was no indication of tracking prior events to behaviors to identify triggers. In an interview on 10/27/23 at 11:25 AM the Administrator indicated Resident B's self-inflicted injury had occurred on 10/17/23. The Administrator indicated they were unaware of 3 documentation entries that reflected the event happened on 10/14/23. The Administrator indicated they were made aware of Resident B's self-injury on 10/17/23. RN 4 indicated they were present when the Administrator was made aware of the event of 10/17/23. The Administrator and RN 4 indicated the physician and facility management should have been made aware immediately. The Administrator indicated the facility had been without a full time Social Service Director (SSD) until a month ago. In an interview on 10/27/23 at 12:43 PM Registered Nurse (RN) 4 indicated Resident B did not voice a history of trauma, self-harm or suicidal ideation. RN 4 indicated Resident B was self-isolating and			

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	liked to be alone. RN 4 indicated they did not believe self-isolating behavior was a predictor of self-harm. RN 4 indicated a resident who presented with the combination of self-isolation, various mental health diagnoses, no family support, addiction and aggressive behavior would benefit from receiving psychiatric services. RN 4 indicated the facility had been trying to transfer Resident B to a more appropriate environment, but choices were limited due to the resident's age. In an interview on 10/27/23 at 12:53 PM the SSD indicated they had not been employed at the facility when Resident B was admitted. The SSD indicated all residents should be assessed for mental health needs upon admission. The SSD indicated the resident should have been receiving mental health services since the time of admission. The Facility Assessment dated 5/23 indicated the facility would manage the care of individuals with depression, trauma, post-traumatic stress disorder, (PTSD) and other psychiatric diagnoses. The Facility Assessment indicated the facility would identify hazards and risks for residents. The Facility Assessment indicated the facility would identify the causes of psychiatric symptoms and behaviors and implement personalized interventions to maintain psychosocial wellness. This citation is related to complaint IN00419911. 3.1-43(a)(1)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical,			

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	mental and psychosocial well-being of each resident. Based on interview and record review the facility failed to ensure the provision medically related Social Services for 1 of 3 residents reviewed. (Resident B) Findings include: An event reported by the facility to the Indiana Department of Health indicated there was a concern for a resident who had inflicted self-injuries with a razor. In an interview on 10/27/23 at 10:25 AM the Administrator indicated Resident B had self-injured their left arm with a razor. The Administrator indicated they were unaware of how the resident had obtained a razor. Resident B's record was reviewed on 10/27/23 at 10:50 AM. Diagnoses included schizoaffective disorder, bipolar disorder, alcohol dependence, nicotine dependence, major depressive disorder, generalized anxiety disorder, non-Alzheimer's dementia, insomnia, other unspecified behavioral disturbances and impulse disorder. Resident B's current comprehensive Minimum Data Set (MDS) dated 8/8/23 indicated their Basic Interview for Mental Status (BIMS) score was 9 (moderate cognitive impairment). The MDS indicated the resident felt hopeless or depressed, had trouble sleeping, felt tired with minimal energy, felt restless, moved slowly and spoke slowly nearly every day. A physician order dated 8/1/23 indicated Resident B could be treated by a Psychiatrist and a	F 0745	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was referred to psych services and seen on 10-18-23. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken**; All residents who require psych services have the potential to be affected by the alleged deficient practice. An audit will be completed on all residents to ensure they have psych services available if needed by 11-14-23. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Social Service Director inserviced by corporate Social Services to ensure all residents are followed by pscyh services if needed. Social Service Director will audit all new admissions to ensure psych referral is completed if needed X6 months. **4 How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	11/14/2023

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	Psychologist. Resident B's Level 2 Preadmission Screening and Resident Review (PASRR) dated 12/10/21 indicated the resident had an extensive history of inpatient psychiatric admissions due to elopement, refusing medications and physical aggression. The resident was no longer a candidate for assisted living arrangements due to frequent alcohol intoxication and disruptive behaviors. Resident B required specialized mental health services. Resident B's current care plan focus of being newly admitted to the facility dated 8/2/23 and revised on 8/16/23 with a goal of psychosocial, mental and behavioral needs being met dated 11/1/23 indicated the resident had a problem of behaviors. Interventions included allowing time for resident to answer questions and verbalize feelings. Other interventions included behaviors and to follow Level 2 PASSR recommendations. Resident B's behaviors were not specified. Resident B's Level 2 PASSR recommendations were not specified. Resident B's current care plan focus of schizoaffective disorder, substance use disorder, alcohol abuse and alcohol dependence dated 8/13/23 and a goal date of 11/1/23 indicated the resident had a risk of decreased psychosocial wellbeing. Interventions included mental health services. A progress note dated 10/17/23 indicated Resident B had been evaluated due to the facility nursing staff's report of self-inflicted wounds on the resident's left arm. The writer indicated the nursing staff had reportedly observed Resident B's self-mutilation over the weekend on 10/14/23.		**into place;** Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA committee will adjust audits based on findings.	

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	Resident B had indicated their injuries were from scratching. The writer indicated the nursing staff later reported the resident had been eating gloves and placing foreign objects wrapped in gloves inside their body cavities. The writer referred the resident to psychiatric services. A Psychiatry Initial Consult dated 10/18/23 at 11:09 AM indicated Resident B had been evaluated for an initial baseline visit for management of psychotropic medications and psychiatric conditions. The consult indicated Resident B had been admitted to a long-term care facility on 12/3/21 due to a significant history of alcohol and substance abuse which could not be managed in assisted living facilities. Resident B had no permanent address and no support system. Resident B had exhibited poor insight and poor safety awareness at previous facilities. Resident B had displayed behaviors including rapid mood change, striking nursing staff, disobeying facility rules and elopement at previous facilities. The current facility staff had reported removing 3 razors from Resident B's room. The current facility staff had reported Resident B had been eating non-edible items and had placed cigarettes and soap inside their body cavities. Resident B indicated scratches on their arm was due to having had a fall. The writer had then confirmed the facility staff who had worked the previous weekend had observed Resident B cutting themselves with a razor. In an interview on 10/27/23 at 11:25 AM the Administrator indicated Resident B's self-inflicted injury had occurred on 10/17/23. The Administrator indicated they were unaware of 3 documentation entries that reflected the event happened on 10/14/23. The Administrator indicated they were made aware of Resident B's			

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	self-injury on 10/17/23. RN 4 indicated they were present when the Administrator was made aware of the event of 10/17/23. The Administrator and RN 4 indicated the physician and facility management should have been made aware immediately. The Administrator indicated the facility had been without a full time Social Service Director (SSD) until a month ago. In an interview on 10/27/23 at 12:43 PM Registered Nurse (RN) 4 indicated Resident B did not voice a history of trauma, self-harm or suicidal ideation. RN 4 indicated Resident B is self-isolating and likes to be alone. RN 4 indicated they did not believe self-isolating behavior was a predictor of self-harm. RN 4 indicated a resident who presented with the combination of self-isolation, various mental health diagnoses, no family support, addiction and aggressive behavior would benefit from receiving psychiatric services. RN 4 indicated the facility had been trying to transfer Resident B to a more appropriate environment, but choices were limited due to the resident's age. In an interview on 10/27/23 at 12:53 PM the SSD indicated they had not been employed at the facility when Resident B was admitted. The SSD indicated all residents should be assessed for trauma upon admission. The SSD indicated the resident should have been receiving mental health services since the time of admission. The Facility Assessment dated 5/23 indicated the facility would manage the care of individuals with depression, trauma, post-traumatic stress disorder, (PTSD) and other psychiatric diagnoses. The Facility Assessment indicated the facility would identify hazards and risks for residents. This citation is related to complaint IN00419911.			

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	3.1-34(a)			