STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of New Haven	1201 Daly Drive New Haven, IN 46774

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on observation, interview, and record review the facility failed to ensure a resident with a known contagious condition was assessed and care planned for 1 of 3 residents reviewed (Resident E). Findings include: During an interview on 6/13/24 at 2:15 P.M., the Director of Nursing (DON) indicated Resident E had recurrent episodes of head lice after returning from leave of absences (LOA) where she visited with family. She indicated Resident E was to be checked for lice upon return to the facility and if found, staff were to obtain treatment orders. Treatment orders would be put in the physician's orders and communicated to staff in the plan of care. Resident E's record was reviewed on 6/14/24 at 10:14 AM. Diagnoses included adult neglect or abandonment confirmed or suspected, delusional disorder, and major depressive disorder. Resident E's current quarterly Minimum Data Set (MDS), dated [DATE], indicated her Brief Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated the resident required substantial to maximal assistance with bathing, including haircare and personal hygiene. Resident E's current care plan did not address lice infestation, past or present, risk factors or staff protocols. Facility census records indicated Resident E left the facility for a LOA on 4/25/24 and returned on 5/1/24. In an interview, on 6/14/24 at 11:00 A.M., Licensed Practical Nurse (LPN) 2 indicated Resident E had returned from LOA with head lice. She indicated a treatment had been completed and she was isolated. She did not recall any special assessments or protocols being done during the isolation period. Progress notes, dated 5/15/24, indicated Resident E was seen by Nurse Practitioner (NP) 3 for pediculosis capitis (head lice), noticed by the resident 2 days earlier. The note indicated Resident E had tried over the counter permethrin shampoo one day earlier and lice were actively visible in Resident E's hair. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes dated 5/21/24 indicated NP 4 visited Resident E for examination of head and scalp. The note indicated Resident E presented with greasy hair contained in a shower cap, and Resident E had indicated her hair was soaked in olive oil. The note indicated Resident E had been brushing her hair and using a nit comb herself, had a dime sized open, draining wound on her left forehead and indicated staff should assist with use of nit brushing. The note indicated small white areas were present on the scalp that may have been dry skin or nits. Dicloxacillin (an antibiotic) was ordered for cellulitis of the scalp. Progress notes dated 5/23/24 indicated NP 4 examined Resident E with no nits or lice observed. The note indicated nursing should continue nit comb use and monitor for lice. A progress note dated 5/31/24 at 1:00 pm indicated during a visit with her therapist, Resident E indicated she was isolated in her room due to recently having lice. The note indicated Resident E found it hard to stay in her room and wished to leave her room to attend group activities. A progress note dated 6/12/24 at 1:00 PM indicated NP 5 visited Resident E and she was isolated to her room for a lice infestation. Physician orders dated 5/15/24 at 3:49 PM indicated Ivermectin external lotion 0.5% was ordered to be applied to resident E's scalp, left on for 10 minutes and rinsed, as a one-time dose for pediculosis capitis (head lice). No additional orders for head lice treatment were available for review. A current Kardex document (nurse aid assignment sheet) did not include use of any medicated shampoo or special considerations for hair and scalp care. Staff education pertaining to care of a resident with pediculosis was not available for review. Weekly nursing summaries dated 5/1/24, 5/8/24, 5/15/24, 5/24/24, 5/31/24, and 6/7/24 did not indicate the presence of lice, or any entries under other pertinent information. During an interview on 6/14/24 at 12:15 P.M., Resident E indicated NP 3 visited her the previous day, did not see any nits or lice and released her from isolation. Resident E indicated she was in isolation for about 4 weeks, and she was happy to be able to shower. She indicated she had been washing her hair in the bathroom sink because she couldn't leave her room and the woman she shared a bathroom with didn't like it. She indicated a staff member had brought her olive oil and a shower cap at one point to attempt to treat her condition. In an interview on 6/14/24 at 11:32 AM, the DON indicated she could not find an order for isolation and did not know when Resident E's isolation began or ended. She indicated formal assessments of Resident E's lice were not conducted and she could not find documentation of residents sharing her bathroom, or otherwise in proximity, being checked for lice. She indicated she did not find any additional provider orders for treatments, a plan of care for infestation with lice, or staff education on lice protocols. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, undated, titled head Lice and Scabies exposure and treatment, provided by the Regional Nurse Consultant (RNC) indicated the nurse should assess the resident with signs such as itching, scratching, rash, nits or lice, report findings to the practitioner and obtain a treatment regimen. The policy indicated treatment should be conducted as ordered and the infested resident should be placed on transmission-based precautions and placed in a single occupancy room away from other residents to avoid transmission. The policy indicated personal clothing, bedding and linens should be decontaminated by washing in hot water. Items unable to be laundered should be dry cleaned or sealed in a plastic bag for 2 weeks. Combs and brushes should be soaked in hot water, at least 130 degrees, for at least 5-10 minutes. A current policy, undated, titled Isolation- Categories of Transmission-Based Precautions provided by the RNC indicated isolation precautions should be used when caring for residents who are diagnosed with or suspected to have communicable diseases. The policy indicated contact isolation precautions should be used in residents with a diagnosis of pediculosis. This citation is related to complaint IN00436491. 3.1-37(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to ensure residents were not given psychotropic medications without specific targeted behaviors identified and non-pharmacological interventions in place for 2 of 3 residents reviewed for unnecessary psychotropic medications (Resident D and Resident J). Findings include: 1. On 6/12/24 at 11:43 A.M., Resident D's record was reviewed. Diagnoses included dementia, chronic pain, generalized anxiety disorder, sleep disorder and major depressive disorder. Resident D was currently hospitalized for a change in condition. A quarterly MDS (Minimum Data Set) assessment, dated 3/4/24, indicated the resident had no cognitive impairment and no behaviors. She had several mood indicators including feeling hopeless; trouble sleeping/sleeping too much; having little energy; moving slowly/fidgety or restless; and trouble concentrating; indicating moderate depression. She was prescribed antidepressant and opioid medications but the MDS did not note any prescribed antipsychotic medications. Care Plans and dates initiated/revised indicated the following: -Initiated 3/8/24: Resident D was at risk for alterations in mood due to verbalization of mood indicators including little interest in doing things, feeling down, depressed and hopeless; trouble falling and staying asleep, feeling tired and having little energy; trouble concentrating and moving slowly. The goal was for her mood to improve as evidenced by a decrease in the frequency of mood symptoms. Interventions included: Notify behavioral health specialist of changes or no improvement in her mood; encourage her to express her feelings; administer medications as ordered and observe for adverse side effects; assist the resident and family to identify strengths, positive coping skills and reinforce these; labs as indicated; and pharmacist to review medication regimen. -Revised 7/29/21: The resident had difficulty sleeping due to sleep disturbance. The goal was for her to wake up refreshed and not be fatigued during the day. Interventions were to administer medications as ordered; assess for pain and treat as indicated; and assess for symptoms of depression or anxiety and treat as indicated. -Revised 12/23/23: The resident had behavior symptoms of seeing/talking to people not present, making false statements and agitation. Interventions were non-pharmacologic and included postponing care when agitated; listening to her needs; maintain safe environment; and provide personal space. -Revised 6/4/23: The resident exhibited behavior symptoms of shortness of breath, repetitive movements, and panic attacks when feeling unwell or during bad weather. Interventions were non-pharmacologic and included: assess resident's needs; allow her to vent her feelings; and document her behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Revised 5/18/23: The resident received psychotropic medications and was at risk for side effects of antidepressant medication and sleep aid. Interventions included to administer medications as ordered and observe for adverse reactions. A change in condition note, dated 5/28/24 at 9:17 p.m., indicated the resident had altered mental status, was being sent to the hospital for evaluation and treatment. She remained at the hospital for 2 days with a diagnosis of sepsis related to a urinary tract infection. She returned to the facility on [DATE] with orders for the following psychotropic medications: Cymbalta (antidepressant), and Trazodone (sleeping pill). An Admission assessment, dated 5/30/24 at an unknown time, indicated the resident had returned to the facility per ambulance, had been yelling and screaming upon arrival. She was placed in bed and positioned for comfort. She was alert and oriented to self and had no signs or symptoms of pain/discomfort. Delusions and hallucinations were present. The family and NP were notified of her return to the facility. A MAR (Medication Administration Record), dated May 2024, indicated on 5/30/24 at 10:43 p.m., Resident D was administered Haloperidol Lactate (anti-psychotic) injection solution-inject 5 mg intramuscularly (IM) one time only for anxiety/agitation. The order for Haloperidol was given by the medical NP. A behavior symptom monitoring form, dated 5/30/24 at 9:59 p.m. and 5/31/24 at 5:59 a.m., 7:49 a.m., and 9:26 p.m., indicated the resident had no behaviors observed. There were no other entries for those dates on the monitoring form. There was no documentation in the nurse progress notes regarding the resident's re-admission to the facility, her condition, behaviors exhibited requiring use of an anti-psychotic, notification to the provider, notification of family prior to use of IM Haldol, or follow up documentation after administration of the medication. A medical NP progress note, dated 5/31/24 at an unknown time, indicated the resident was visited following readmission to the facility from the hospital. The resident had gone out for confusion and had been diagnosed with a urinary tract infection with sepsis. She remained confused and delusional. Her mentation had been significantly declining, she had become confused/disoriented and continuously yelled out in pain. Several of the resident's medications had been discontinued while hospitalized . Her pain medication and anti-anxiety medication would be restarted due to her yelling out. The progress note hadn't indicated the resident had been ordered Haldol IM on 5/30/24. There was no indication the psyc provider had been contacted regarding behavior or as a consult prior to Haldol being ordered or administered. 2. On 6/13/24 at 2:39 P.M., Resident J's record was reviewed. Diagnoses included chronic obstructive pulmonary disease (COPD) and major depressive disorder. A quarterly MDS (Minimum Data Set) assessment, dated 4/18/24, indicated Resident J had no cognitive impairment and no behaviors. She had several mood indicators which included feeling hopeless; trouble sleeping/sleeping too much; having little energy; moving slowly/fidgety or restless; and trouble concentrating which indicated moderate depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, revised on 4/14/24, indicated the resident was at risk for alterations in mood due to verbalization of mood indicators including little interest in doing things, feeling down, depressed and hopeless; trouble sleeping, feeling tired and having little energy; trouble concentrating and moving slowly. The goal was for her mood to improve as evidenced by a decrease in the frequency of mood symptoms. Interventions were: Notify behavioral health specialist of changes or no improvement in her mood; encourage her to express her feelings; administer medications as ordered and observe for adverse side effects. An NP (Nurse Practitioner) progress note, dated 5/7/24, indicated the following: Resident J was seen following re-admission to the facility from the hospital for UTI (Urinary Tract Infection). The resident had been seen on previous visits on 3/13/24 for respiratory symptoms; 3/28/24 for increased nerve pain; 4/18/24 for refill of pain medication which had recently been decreased due to the resident having intermittent confusion; and 4/23/24 for complaints of right shoulder pain and resident's request for referral to ortho. None of the previous visits nor current visit indicated the resident had symptoms of anxiety which required use of Xanax. An NP progress note, dated 6/4/24, indicated the resident had been seen for congestion. During the visit, the resident requested the Xanax be refilled and orders given to re-order the medication. The progress note hadn't indicated the reason why the resident was taking Xanax or the need for intermittent use of the medication. An NP progress note, dated 6/11/24, indicated the resident had a fall on this day and had landed on her right forearm and knee. The resident indicated she'd had intermittent dizziness the past couple of days. Resident J was on several sedating medications including Percocet (narcotic pain medication), Ropinirole (for restless leg syndrome), Cyclobenzaprine (muscle relaxant), and Xanax (anti-anxiety). The plan was to decrease the dosage of her muscle relaxant. The progress note hadn't indicated the reason for the resident being prescribed Xanax nor need for intermittent use of the medication. A psychiatric NP progress note, dated 5/8/24, indicated the resident was being seen for a history of anxiety and depression. The resident had no behaviors charted since admission to the facility. The resident was alert and a good historian. She admitted to increased depressive symptoms and was agreeable to increasing the dose of her anti-depressant. Her past use of psychotropic medication included Xanax. Assessment and plan was to discontinue 1 of her prescribed anti-depressants and increase the dose of her other antidepressant medication (Cymbalta) for recurrent moderate major depressive disorder and generalized anxiety. The resident's medication, used to help her sleep, was increased to 100 mg of Trazodone by mouth at bedtime for sleep disorder. The progress note hadn't indicated the resident recently was prescribed Xanax, reason for use, or associated behaviors. On 6/14/24 at 11:37 A.M., LPN 2 (Licensed Practical Nurse) was interviewed. She indicated Resident J had no behaviors or indicators of anxiety but would request Xanax when she felt anxious. Resident J had no plan of care nor diagnosis of anxiety prior to being seen by the psychiatric NP on 5/8/24, who documented the resident had depressive symptoms and generalized anxiety which would be treated with Cymbalta (anti-depressant). There was no documentation of behaviors associated with the resident feeling anxious, no non-pharmacological interventions to be tried prior to administering Xanax, nor was there documentation of potential for adverse effects due to intermittent use of Xanax in addition to simultaneous use of other sedating medications which the resident was prescribed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 10:33 A.M., the SSD-Social Services Director was interviewed. She indicated staff were to document behaviors in the resident's chart every shift. She would review behaviors on the 24 hour report sheet and review the number of behaviors daily and monthly. She indicated residents who have mood and/or behaviors symptoms requiring use of psychotropic medications either routinely or on as needed basis, were to have a care plan and behavior monitoring to assist with assessing if interventions and medication use was effective. On 6/13/24, information for Alprazolam (Xanax), was retrieved from PDR.net (Prescribers Digital Reference), which indicated Xanax was a benzodiazepine medication prescribed for panic disorder and generalized anxiety disorder. It had a black box warning for risk for fatal respiratory depression in those with COPD or pulmonary disease and when used with other sedating medications. Xanax should be used cautiously in debilitated adults who were more sensitive to the effects of benzodiazepines. There's a higher risk of falls in the elderly due to drowsiness and decreased level of consciousness. All benzodiazepines increase the risk of cognitive impairment, delirium, falls, and fractures. On 6/13/24 at 12:30 P.M., the SSD provided a current copy of the facility policies titled Mood and Behavior Management and Psychotropic Management indicated: Mood and Behavior Management: Residents are provided with 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 .A care plan should be initiated for any behavioral symptom that affects, or can affect, the resident or others. All residents who are taking antipsychotic, anxiolytic, sedative/hypnotic, or anticonvulsant medication routinely or as needed are to have corresponding plans of care and to be included in the mood and behavior monitoring program to assist with assessing the efficacy of interventions and medication use .All mood and/or behavioral symptoms are reported to nursing .Any new or worsening mood and/or behavioral symptoms are documented in a progress note completed by nursing or social services Psychotropic Management: Psychotropic medications are managed in collaboration .Each resident receiving psychotropic medication will have a supporting diagnoses .appropriate indication for use .and Gradual Dose Reduction .Residents receiving an order for a PRN psychotropic medication will have a 14 day stop date entered in the orders with re-evaluation of medication documented in the clinical record. All residents who are taking antipsychotic, anxiolytic, sedative/hypnotic medications are required to have a behavior monitoring program in place identifying targeted behavioral symptoms being monitored as well as personalized non-pharmacological interventions .Resident who are on the behavior program will be reviewed monthly for a quantification of behaviors and evaluation of interventions This tag relates to Complaints IN00434551, IN00436439, and IN00436524. 3.1-48(a)(6) 3.1-48(b)(1)