STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of West Allen	6050 S Cr 800 E 92 Fort Wayne, IN 46814

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on observation, interview and record review the facility failed to ensure services were provided for the grooming of facial hair for 1 of 2 residents reviewed (Resident 16). Findings include: On 7/24/24 at 10:34 AM Resident 16 was observed sitting in their wheelchair in the hallway. Resident 16 was observed to have a full mustache of dark hair. Resident 16's record was reviewed on 7/25/24 at 1:01 PM. Diagnoses included dementia, diabetes, stroke, pain in right shoulder, pain in left shoulder, hemiplegia (paralysis) of their left side and hemiparesis (weakness) of their left side. Resident 16's Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 10 (moderate cognitive impairment). The MDS indicated Resident 16 required substantial or maximum assistance with personal care such as washing face, combing hair, shaving and applying makeup. Resident 16's Care Plan, dated 11/8/23, indicated the resident needed assistance with activities of daily living (ADLs). The target goal was for the resident to have their needs met daily with assistance from staff through 11/15/24. Interventions included staff assistance with bed mobility, eating, personal hygiene, toilet use, the use of a mechanical lift for transfers, encouraging participation, praising resident efforts, observing and reporting changes in ability to participate in ADLs and screening for the need for a therapy evaluation. Resident 16's Care Plan did not indicate the resident required assistance with grooming of facial hair. Resident 16's Care Plan did not indicate if the resident had a preference about their facial hair being shaved or being left intact. Resident 16's Kardex (care plan summary for providers of direct care) dated current as of 7/29/24 consisted of the following items: 1. Bathing-showers on the evening shift every Wednesday and Saturday (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Personal Hygiene-staff assistance 3. Oral Care-specify dentures, natural teeth, partials or no teeth Resident 16's Kardex did not indicate the resident required assistance with grooming of facial hair. Resident 16's Kardex did not indicate if the resident had a preference about their facial hair being shaved or being left intact. In an interview on 7/30/24 at 9:43 AM, the Administrator indicated Resident 16 often refused personal care. The Administrator indicated they were unaware the grooming of facial hair had not been included on the resident's Care Plan or Kardex. The Administrator indicated the grooming of facial hair should be offered by the staff- even for female residents. The Administrator agreed including the grooming of facial hair on the Care Plan and the Kardex would remind the staff to offer assistance. In an interview on 7/30/24 at 10:34 AM, the Regional Nurse Consultant and the Director of Nursing (DON) indicated Resident 16 did not have facial hair on 7/30/24. The DON indicated Resident 16 would allow a certain staff member to assist with personal care. The DON indicated Resident 16's refusals of personal care, the resident's preference to have facial hair removed and their preference for a certain staff member should have been on the resident's Care Plan and Kardex. The Regional Nurse Consultant indicated Resident 16's preferences included on the Kardex would be beneficial in making all direct care staff aware of the resident's needs. In an interview on 7/30/24 at 11:20 AM, the Administrator indicated a resident diagnosed with dementia could possibly be unaware of their facial hair. The Administrator indicated facial hair on a woman could be a dignity issue. A current facility policy dated 2001 and revised 3/2018 provided by the Administrator on 7/30/24 at 9:35 AM indicated the facility would provide services according to the resident's MDS assessment for bathing, dressing, grooming and oral care. The policy indicated refusal of personal care by a resident with dementia would be investigated to determine the underlying cause for refusal. 3.1-38(a)(3)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46156 Based on observation, interview and record review, the facility failed to identify triggers to prevent potential re-traumatization for 2 of 11 residents reviewed for mood/behavior (Resident 3 and Resident 16). Findings include: 1. In an observation on 7/24/24 at 10:40 AM, Resident 3 was observed laying in her bed yelling. A staff member arrived, and the resident indicated she wanted to get up. The resident's call light was attached to her bed linens within arm length. In an observation on 7/25/24 at 2:10 PM, Resident 3 was observed laying in her bed yelling out from her room. A staff member arrived, and the resident indicated she needed her brief changed. The resident's call light was attached to her bed linens within arm length. In an observation on 7/26/24 at 12:32 PM, Resident 3 was observed sitting in her wheelchair at the nurses station counter with her lunch in front of her. The resident's arms were shaking, and the Administrator was assisting her. Resident 3's record was reviewed on 07/25/24 at 12:37 pm. Diagnoses included paranoid schizophrenia, schizoaffective disorder, personality disorder, obsessive-compulsive personality disorder, generalized anxiety disorder, severe recurrent major depressive disorder with psychotic episodes, and intellectual disability. Resident 3's current annual Minimum Data Set (MDS) assessment, dated 6/17/24, indicated her Basic Interview for Mental Status (BIMS) score was 11 (moderate cognitive impairment). The MDS indicated the resident experienced 7-11 days in a 2-week period of decreased interest or pleasure in doing things, feeling down, depressed or hopeless, feeling tired or having little energy, feeling bad about herself, she was a failure or had let herself or her family down, and had trouble concentrating on things such as reading the newspaper or watching TV. The MDS indicated the resident experienced 2 - 6 days in a 2-week period of trouble falling or staying asleep or sleeping too much and a poor appetite or overeating. The MDS indicated Resident 3 was on antipsychotics, antidepressants, and antianxiety medications in the last 7 days. Resident 3's Preadmission Screening and Resident Review (PASRR), dated 9/1/22 with an effective date of 8/25/22, indicated she had experienced sexual abuse as a child and was sexually assaulted as a teen. The PASRR indicated she had extreme focus on sexual thoughts, disrobed, rolled around on the ground, thought of ending her life by beating herself up, angry behaviors, chose not to eat, take medications, and/or shower, attempted to leave a group home, and distrust or belief others were trying to harm her, were watching her, or were planning to put her in jail. Resident 3's Initial Social Service History, dated 8/11/23, indicated the resident had some schooling, had some mental disabilities, had been raped and molested as a child over and over, and had been in and out of facilities. Resident 3's Social Service History did not identify the resident's specific identified triggers that could cause Resident 3's re-traumatization of her life experiences. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's Adverse Childhood Experience (ACE) Questionnaire, dated 8/11/23, indicated the resident answered yes to 10 of 10 questions. This indicated Resident 3 was at high risk to experience toxic stress related to agressive behaviors and sleep diturbances. Resident 3's Psychiatry Progress Notes, dated 7/23/24, indicated the resident was diagnosed with a mental illness at [AGE] years old. The progress note indicated the resident was sexually abused as a child and assaulted as a teen. The progress note indicated the resident was divorced and had two children she had given up for adoption. The progress note indicated the resident experienced severe distrust and focused on frequent sexual thoughts. The progress note indicated the resident had a history of rolling on the floor, had beat herself up, had thoughts of ending her life, and had noncompliance with care with a current complaint of not sleeping well. The progress notes indicated the resident hallucinated; she heard voices singing to her. The progress note indicated the resident had multiple admissions at the State Hospital with Electroconvulsive therapy (ECT) (psychiatric treatment where a generalized seizure is electrically induced to manage refractory mental disorders), and psychiatric hospitals. The most recent admission was due to psychosis and delusions. Resident 3's current Kardex (brief overview of each patient, updated every shift, used by the facility's Certified Nursing Assistant), dated 7/29/24, did not identify Resident 3's specific identified triggers with a potential to cause re-traumatization of her life experiences. A physician's order, dated 8/10/23, indicated Resident 3 could receive psychiatrist services. A physician's order, dated 8/10/23, indicated Resident 3 received Invega 6 milligrams (mg) daily and Invega 3mg at bedtime for depressive type schizoaffective disorder. A physician's order, dated 3/20/24, indicated Resident 3 received risperidone 0.5mg daily for depressive type schizoaffective disorder and major recurrent depressive disorder with psychotic symptoms. A physician's order, dated 3/7/24, indicated Resident 3 received Ativan 1mg two times a day for anxiety. Resident 3's behavior symptoms task monitor indicated the resident displayed the following behaviors 7/1/24 through 7/29/24: Behaviors Number of times -Yelling/Screaming: 38 -Kicking/Hitting: 1 -Wandering: 2 -Abusive Language: 8 -Rejection of Care: 2 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's current care plan titled Psychosocial Wellbeing Problem, revised 7/08/2024, indicated the resident's life experience included being raped, growing up in a home with emotional and physical abuse, family discord, and witnessing abuse. Resident 3's care plan goal, target date 11/21/24, indicated she would demonstrate the ability to seek out staff support when feeling frustrated or provoked. Interventions included 1) consult with pastoral care, social services and psych services, 2) encourage resident and family/representative to attend quarterly care plan meetings and to be involved in the plan of care, and 3) when conflict arises, remove resident to a calm safe environment and allow her to vent/share feelings. The care plan did not include resident specific identified triggers with a potential to cause re-traumatization of her life experiences. Resident 3's care plan goal, target date 11/21/24, did not include the elimination or reduction of resident specific identified triggers with a potential to cause re-traumatization of her life experience. Resident 3's current care plan titled Behavior Symptoms, revised 7/8/24, indicated the resident experienced behavioral symptoms related to her life experiences of thoughts others talked about her, thoughts others would not listen to her, thoughts others would not give her attention, repetitive noises and movements, being anxious, yelling out, and screaming. Interventions included she would demonstrate the ability to seek out staff/caregiver support when she felt frustrated. The care plan did not include resident specific identified triggers with a potential to cause re-traumatization of her life experiences. Resident 3's care plan goal, target date 11/21/24, did not include the elimination or reduction of resident specific identified triggers with a potential to cause re-traumatization of her life experience. 45794 2. On 7/27/24 at 10:33 AM Resident 16 was observed sitting in their wheelchair in the hallway outside their room. Resident 16 did not make eye contact when spoken to. Resident 16 declined being interviewed. Resident 16's record was reviewed on 7/25 24 at 1:01 PM. Diagnoses included psychotic disorder with delusions, major depressive disorder, dementia, anxiety, visual hallucinations and cerebral infarction (stroke). Resident 16's Quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident's Brief Interview for Mental Status (BIMS) score was 10 (moderste cognitive impairment). The MDS indicated Resident 16 had rejected care. The MDS indicated Resident 16 had dementia, (non-Alzheimer's) anxiety, depression and psychotic disorder. The MDS indicated Resident 16 had episodes of refusing care. Resident 16's Behavior Monitoring and Interventions Report dated 7/1/24 through 7/29/24 indicated the number of times the resident had displayed the following behaviors: 1. Wandering-9 2. Delusions-2 3. Repetitive motions-2 4. Pick at self-2 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Pushing others-1 6. Disruptive sounds-1 7. Throwing/smearing bodily waste-1 8. Agitation-1 9. Scratching self-1 Resident 16's Care Plan dated 11/25/23 indicated the resident displayed behaviors of visual hallucinations, delusions, yelling, screaming, abusive language and refusal of care. The target goal was Resident 16 would allow support from the staff during the behaviors by 11/15/24. Interventions included medications as ordered, meeting the resident's needs, offering coloring supplies, providing the resident with choices, approaching later and placing the resident at the nurse station. Resident 16's Care Plan did not include attempting to identify resident specific triggers or stressors. Resident 16's Care Plan did not include attempting to identify the resident's specific stressors or triggers with a potential to lead to visual hallucinations, delusions, yelling, screaming, abusive language or refusal of care. Resident 16's Care Plan dated 11/25/23 indicated the resident had a history of trauma, post- traumatic stress disorder, (PTSD) memory problems and sadness as evidenced by sad face, sad affect and statements of sadness. The target goal was for Resident 16 to have positive social interactions with peers by 11/15/24. Interventions included to encourage the resident to share their concerns and wishes and ensure the resident's preferences were communicated to caregivers. Resident 16's Care Plan did not include attempting to identify resident specific triggers or stressors. Resident 16's Care Plan did not include attempting to identify the resident's specific stressors or triggers with potential to cause the resident to make sad statements, have a sad face or have a sad affect. Resident 16's Care Plan dated 11/25/23 indicated the resident had verbalized or displayed the following: feeling down, feeling depressed, feeling hopeless, trouble falling asleep, trouble staying asleep, feeling tired, poor appetite and feeling restless. The target goal was for the resident to seek out staff to vent and to encourage activities with peers through 11/15/24. Interventions included encouraging the resident to express feelings. Resident 16's Care Plan did not include attempting to identify resident specific triggers or stressors. Resident 16's Care Plan did not include specific stressors or triggers with a potential for the resident to feel down, feel depressed, feel hopeless, have trouble falling asleep, have trouble staying asleep, feel tired, have poor appetite or feel restless. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 16's Care Plan did not indicate the resident displayed behaviors of wandering, pushing others, throwing or smearing bodily waste, picking at self or scratching self. Resident 16's Kardex (care plan summary for providers of direct care) dated current as of 7/29/24 indicated the resident required assistance with the following: 1. Safety-anti-tippers to wheelchair, mattress to floor, offer of getting up if restlessness is noted and re-education on use of the call light 2. Bathing-showers on the evening shift every Wednesday and Saturday 3. Eating-mechanically altered diet, observe for choking, difficult swallowing, coughing, holding food in their mouth, appearing concerned during meals and refusing to eat 4. Transferring-mechanical lift 5. Resident Care-pressure relieving mattress to bed, pressure relieving cushion to wheelchair 6. Bed Mobility-staff assistance 7. Personal Hygiene-staff assistance 8. Oral Care-specify dentures, natural teeth, partials or no teeth 9. Toileting-assist with toileting Resident 16's Kardex did not indicate the resident had a history of trauma, depression, anxiety, visual hallucinations or delusions. Resident 16's Kardex did not indicate they displayed behaviors of agitation, verbal aggression, refusal of care, delusions or visual hallucinations. Resident 16's Kardex did not indicate specific resident stressors or triggers with a potential to cause re-traumatization, anxiety, agitation, delusions, visual hallucinations or refusal of care. Resident 16's Kardex did not include interventions to minimize the resident's behaviors. Resident 16's Preadmission Screening and Resident Review (PASRR), dated 2/29/24, indicated the resident's diagnoses were psychotic disorder, unspecified depressive disorder, unspecified anxiety disorder and major neurocognitive disorder (dementia) due to multiple etiologies with behavioral disturbance. Resident 5's PASRR indicated their BIMS score was 5 (severe cognitive impairment). A physician order dated 7/23/24 indicated Resident 16's sleep disturbances were to be documented every night due to trouble sleeping. A Psychiatry Progress Note dated 7/23/24 at 6:37 PM indicated Resident 16 had a history of refusal of medications, therapy and personal care. The note indicated Resident 16 was often tearful. Resident 16 had indicated they had been sad for a long time and did not know what caused the sadness. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavioral Health Progress Note dated 4/9/24 at 5:47 PM indicated Resident 16 had lived at home with their husband prior to having a fall in the garage. Resident 16 had remained on the garage floor for an undetermined amount of time. Resident 16's husband had a difficult time caring for the resident due to their progression of dementia. Resident 16 had often been paranoid and agitated which resulted in many arguments between the resident and their husband. Resident 16 had served in the Women's Army Corp where they worked with the emergency medical technicians and the military police. In an interview on 7/29/24 at 10:45 AM, the Administrator indicated they were unaware of the need for identification of triggers for trauma survivors. The Administrator indicated Social Services was responsible for mental health Care Plans. In an interview on 7/30/24 at 10:52 AM, the Social Service Director (SSD) indicated they had been employed at the facility for 3 weeks. The SSD indicated they were in the process of reviewing all the facility Care Plans. The SSD indicated each resident should be assessed for the history of trauma upon admission to the facility. A current facility policy dated 1/2/24 provided by the Director of Nursing (DON) on 7/29/24 at 10:30 AM, indicated the facility would identify triggers with a potential to re-traumatize trauma survivors. The policy indicated the facility would identify trigger specific interventions and add the interventions to the resident's Care Plan. For residents who were resistant to sharing their trauma history details, the policy indicated the facility would still make attempts to identify resident specific triggers and formulate Care Plan interventions to minimize the resident's trauma response. A current facility policy dated 1/2/24 provided by the DON on 7/29/24 at 10:30 AM indicated resident specific behavioral Care Plan interventions would be made available on the resident's Kardex.