PRINTED: 11/01/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC					OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155618	B. WI	NG		10/20/2022		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032 ID (X5)					
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
	REGULATORT ON	CESC IDENTIFTING INFORMATION	_	IAU			DATE	
F 0000 Bldg. 00	Home Complaints I IN00389712 and IN the Investigation of IN00387578. Complaint IN00387 Federal/state deficie allegations are cited Complaint IN00383 deficiencies related Complaint IN00389 deficiencies related Complaint IN00392 deficiencies related Complaint IN00387 deficiencies related Survey dates: Octob Facility number: 00 Provider number: 1 AIM number: 2001- Census Bed Type: SNF/NF: 29 SNF: 25 Residential: 70 Total: 124	1 at F758. 18851 - Substantiated. No to the allegations are cited. 19712 - Substantiated. No to the allegations are cited. 19263 - Substantiated. No to the allegations are cited. 19578 - Substantiated. No to the allegations are cited. 19579 - Substantiated. No to the allegations are cited. 1959 - Substantiated. No to the allegations are cited. 1959 - Substantiated. No to the allegations are cited. 1959 - Substantiated. No to the allegations are cited. 1959 - Substantiated. No to the allegations are cited. 1959 - Substantiated. No to the allegations are cited.	F 00	00	The Creation and submission the Plan of Correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. provider respectfully requests 2567 Plan of Correction be the letter of credible allegation and REQUESTS DESK REVIEW ILIEU OF A POST SURVEY REVISIT on or after October 22022.	ot s forth s or This the e		
	Census Payor Type Medicare: 12 Medicaid: 29							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

John Seib Executive Director 10/28/2022

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 865711 Facility ID: 001149 If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
		155618	B. WI			10/20	/2022		
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID BROVIDED'S DI AN OF		ON I	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	BE	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	TIMATE	DATE		
	Other: 13 Total: 54								
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.								
	Quality review was completed on October 24, 2022.								
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic								
		rehensive assessment of a ty must ensure that							
	psychotropic drug	_							
	reductions, and be	s receive gradual dose ehavioral interventions, ontraindicated, in an effort							
	_ , , , ,	sidents do not receive s pursuant to a PRN order							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

865711

Facility ID: 001149

If continuation sheet

Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618			(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/20/2022			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
	a diagnosed spect documented in the \$483.45(e)(4) PR drugs are limited provided in \$483. physician or present that it is appropriate extended beyond document their ramedical record are the PRN order. \$483.45(e)(5) PR drugs are limited renewed unless the prescribing practifor the appropriate Based on interview failed to ensure sign psychotropic mediculate to ensure sign psychotropic mediculate to ensure sign psychotropic residents reviewed use. Findings include: 1. The record for Record f	ation is necessary to treat diffic condition that is e clinical record; and N orders for psychotropic to 14 days. Except as 45(e)(5), if the attending cribing practitioner believes ate for the PRN order to be 14 days, he or she should tionale in the resident's and indicate the duration for N orders for anti-psychotic to 14 days and cannot be the attending physician or tioner evaluates the resident eness of that medication. If and record review, the facility med consents for the use of cations (a drug which affects oughts, or perception) were resident or resident's ed to the risks and benefits of medications for 3 of 3 for psychotropic medication esident B was reviewed on the 10:06 a.m. Diagnoses included, downward to to the facility on August to the facility of the	F 0758	F 758 Free from Unnecessal Meds /PRN Use 1. What corrective action will be accomplished for the residents found to have been affected by the alleged deficient practice? - Resident B was dischast from the facility at the time of citation and submission of the plan of correction. - Resident C was dischast from the facility at the time of submission of this plan of correction. - Facility reviewed the prescribed psychotropic medications with Resident D including but not limited to the risks and benefits thereof and documented consent to the second with the second medication of the second m	ns ose en arged f is arged f		

CLIVILIO	WIEDICHKE & MEDIC	THE SERVICES			012 110.0900 009	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155618	B. WING		10/20/2022	
			CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹		N PENNSYLVANIA ST		
MA IEST	IC CARE OF CARM	4 ⊏1		EL, IN 46032		
IVIAJEGI			CARWI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CARMEL (X4) ID SUMMARY STATEMENT OF PROFIX (EACH DEFICIENCY MUST BE PROBLE) TAG REGULATORY OR LSC IDENTIFY 11, 2022, indicated to give mirtage (Remeron-an antidepressant med milligrams (mg) at bedtime for approximately supplied to the supplier of the su	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	· · ·			on or before October 28, 2022		
	(Remeron-an antide	epressant medication) 7.5		 Facility audited all reside 	nts	
	milligrams (mg) at	bedtime for appetite simulate		in the facility for use of		
	related to depression. The medication was			psychotropic medications on		
	discontinued on Au	igust 11, 2022.		October 28, 2022, to ensure th	at	
				the resident or resident's		
				representative have been educ	cated	
	indicated to give m	irtazapine 7.5 mg, on odd days,		regarding the risks and benefit	s of	
	for 7 days related to	appetite simulate related to		the medication and consent for	r	
	depression.			use was documented.		
				2. How other residents		
	A physician's order	, dated July 29, 2022, indicated		having the potential to be		
	to give olanzapine	(an antipsychotic medication)		affected by the same deficien	t	
	2.5 mg twice a day	for delusional disorder.		practice will be identified and		
				what corrective action will be)	
	A physician's order	, dated July 29, 2022 to August		taken?		
	04, 2022, indicated	to give trazodone (an		- All residents using		
	antidepressant med	ication) 100 mg at bedtime for		psychotropic medications have	the the	
	insomnia.			potential to be affected by the		
				alleged deficient practice.		
	A physician's order	, dated August 04, 2022 to		- Facility updated its		
	August 10, 2022, ir	ndicated to give trazodone 100		"Psychotropic Management"		
	mg times three (3)	tablets at bedtime for insomnia.		policy in regard to documentati	ion	
				of informed consent.		
	A physician's note,	dated August 11, 2022 at 10:28		- Facility audited all reside	nt	
	p.m., indicated the	family requested Resident B be		files for use of psychotropic		
	removed from traze	odone and Remeron related to a		medications on or before Octo	ber	
	concern of too muc	h medication.		28, 2022, to ensure that the		
				resident or residents'		
	During an interview	v, on October 18, 2022 at 2:00		representative have been educ	cated	
	p.m., the Corporate	Support Nurse indicated the		regarding the risks and benefit	s of	
	facility did not have	e a consent on file for the use		psychotropic medications and		
	of psychotropic me	dications for Resident B.		consent for use was document	ed.	
				Any deficiencies were correcte	d	
	2. During an interv	iew, on October 20, 2022 at		immediately.		
	10:34 a.m., Resider	nt C indicated he was not sure if		- Facility Nursing staff will	be	
	he had signed a cor	sent for psychotropic		in-serviced by ED/Designee or		
	medication use.	- · · · · ·		before October 28, 2022, to		
				ensure that informed consent f	or	
The record for Resident C was reviewed on		dent C was reviewed on	1	nevehotronic medications is		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF F	PROVIDER OR SUPPLIER	·		ADDRESS, CITY, STATE, ZIP COD	
MAJESTIC CARE OF CARMEL				N PENNSYLVANIA ST 1EL, IN 46032	
				T +0002	T
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1710		t 8:50 a.m. Diagnoses included,	1710	properly obtained and docum	
		l to, bipolar disease,		per the Psychotropic Manage	
	depression and inso	-		policy.	
	A physician's order	, dated September 30, 2022,		3. What measures will be	
		uphenazine (an antipsychotic		put into place or what syste	
		vice a day for bipolar disorder.		changes will be made to	
		3		ensure that the deficient	
	A physician's order,	, dated October 05, 2022,		practice will not recur?	
	indicated to give qu	etiapine (an antipsychotic		- Facility updated its	
	medication) 200 mg	g three (3) times a day for		"Psychotropic Management"	
	schizophrenia. A facility document, titled "Informed Consent for			policy in regard to documenta	ation
				of informed consent.	
				- Facility Nursing staff wi	
	1	cations," was provided by the		in-serviced by ED/Designee	on or
		on 10/19/22 at 10:55 a.m. The		before October 28, 2022, to	
		etober 06, 2022, indicated a		ensure informed consent for	
		of fluphenazine was obtained		psychotropic medications is	
	_	was missing the signature of		properly obtained and docum	
		otaining the consent and the of the resident or resident		per the Psychotropic Manage	ement
	representative.	of the resident of resident		policy Residents will be review	wod
	representative.			upon admission for use of	veu
	3. The record for Re	esident D was reviewed on		Psychotropic Medications,	
		t 10:53 a.m. Diagnoses included,		including but not limited to	
		to, schizophrenia, anxiety		informed consent.	
	disorder and bipola	-		- Facility staff will obtain	
	_			informed consent for use of	
		, dated August 04, 2022,		psychotropic medications fro	m
	_	spirone (an anti-anxiety		resident or resident represen	tative
	medication) 5 mg d	aily for schizophrenia.		upon admission for existing of	orders
				and with any new orders for	
		, dated March 23, 2022,		psychotropic medications.	
	_	ozac (an antidepressant		1	
	medication) 10 mg	daily for bipolar disorder.		4. How corrective actions will be monitored to ensure	
	A nhysician's order	, dated September 23, 2022,		deficient practice will not re	
		speridone (an antipsychotic		i.e., what quality assurance	cui
				program will be put into pla	ce?
	medication) at bedtime for schizophrenia.			- Audit Tool Psychotropic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/20/2022			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CARMEL			12999 I	STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Management will be utilized by	DATE			
	psychoactive medic A facility documen Psychoactive Medi Executive Director document was not it During an interview a.m., the Executive psychiatric medical admission and if a started. The facility signature of the res admission and if a r The consent was m A facility policy, ti Management," date 2020 and provided October 19, 2022 a obtaining an inform or resident represer During the exit con beginning at 4:18 p Services indicated to policy related to ob psychotropic medic Director indicated t reviewed by the Co	v, on October 20, 2022 at 9:36 Director indicated consent for tions was to be completed on psychiatric medication was a would attempt to get a ponsible party/resident on new medication was started. ore of a notice of side effects. tled "Psychotropic at as revised in September of by the Executive Director on the 10:55 a.m., did not address and consent from the resident attative. ference, on October 20, 2022 a.m., the Regional Director of the facility did not have a training a consent for cation use. The Executive the policy needed to be		Management will be utilized by Executive Director, Director of Nursing and/or designee to monitor compliance. Audits who be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereaft until compliance is maintained at least two consecutive quart - Results of audit tools will presented to the QAPI Commit Monthly to review for compliant and follow-up. Identified noncompliance may result in streeducation and/or disciplinary action. - If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitt to the QAPI committee overse by the ED for review and follows.	ter I for ers. I be ittee nce staff y			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

865711

Facility ID: 001149

If continuation sheet

Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155618	B. WING 10/20/2022			2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				12999 N PENNSYLVANIA ST				
MAJESTIC CARE OF CARMEL			CARMEL, IN 46032					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCE	ACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0000								
DI-I 00								
Bldg. 00	This wisk for all	- Intiti	D O	000		- £		
		le Investigation of Residential	R 0	000	The Creation and submission			
	-	7578. This visit included the			the Plan of Correction does no			
	-	rsing Home Complaints 383851, IN00389712 and			constitute an admission by this			
	IN00387734, IN003	705051, 11N00507/12 allu			provider of any conclusion set in the statement of deficiencies			
	11100372203.				of any violation of regulation.			
	Complaint IN00387	578 - Substantiated. No			provider respectfully requests			
	deficiencies related to the allegations are cited.				2567 Plan of Correction be the			
	activities related to the allegations are clear.				letter of credible allegation and			
	Complaint IN00387754 - Substantiated.				REQUESTS DESK REVIEW I			
	Federal/state deficiencies related to the				LIEU OF A POST SURVEY			
	allegations are cited at F758.				REVISIT on or after October 2	8,		
					2022.			
	Complaint IN00383851 - Substantiated. No							
	deficiencies related	to the allegations are cited.						
	-	712 - Substantiated. No						
	deficiencies related	to the allegations are cited.						
	-	263 - Substantiated. No						
	deficiencies related	to the allegations are cited.						
	Survey date: Octobe	er 18, 19 and 20, 2022						
	Facility number: 00	1149						
	•							
	Residential Census:	70						
	Majestic Care of Ca	armel was found to be in						
	-	0 IAC 16.2-5 in regard to the						
	-	mplaint IN00387578.						
	tonganon or cor							
	Quality review was	completed on October 24,						
	2022.	-						

State Form Event ID: 865711 Facility ID: 001149 If continuation sheet Page 7 of 7