STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00424001 and IN00426976. This visit included the Investigation of Assisted Living Complaints IN00425860 and IN00426915. Complaint IN00424001 - No deficiencies related to the allegations are cited. Complaint IN00426976 - No deficiencies related to the allegationsare cited. Complaint IN00425860 - State deficiencies related to the allegations are cited at R352. Complaint IN00426915 - No deficiencies related to the allegations are cited. Survey dates: February 5, 6 and 7, 2024. Facility number: 001149 Provider number: 155618 AIM number: 200145500 Census Bed Type: SNF/NF: 30 SNF: 24 Residential: 85 Total: 139 Census Payor Type: Medicare: 11 Medicaid: 23 Other: 20 Total: 54 Majestic Care of Carmel was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00424001 and IN00426976.	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 an violation of regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and REQUESTS DESK REVIEW IN LIEU OF POST SURVEY REVISIT on or after March 8, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Seib	Executive Director	02/29/2024

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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	Quality review was completed on February 15, 2024.			
R 0000 Bldg. 00	This visit was for the Investigation of Assisted Living Complaints IN00425860 and IN00426915. This visit included the Investigation of Nursing Home Complaints IN00424001 and IN00426976. Complaint IN00425860 - State deficiencies related to the allegations are cited at R352. Complaint IN00426915 - No deficiencies related to the allegations are cited. Complaint IN00424001 - No deficiencies related to the allegations are cited. Complaint IN00426976 - No deficiencies related to the allegationsare cited. Survey dates: February 5, 6 and 7, 2024. Facility number: 001149 Residential Census: 85 Thi State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 15, 2024.	R 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 an violation of regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and REQUESTS DESK REVIEW IN LIEU OF POST SURVEY REVISIT on or after March 8, 2024.	
R 0352 Bldg. 00	410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided.			

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	(4) Progress notes. Based on interview and record review, the facility failed to maintain a complete and accurate medical record to indicate an assessment had been completed and documented for a resident who experienced a change in condition for 1 of 1 resident reviewed for accurate and complete documentation in the medical record. (Resident B) Finding includes: During an interview, on 2/6/24 at 10:42 a.m., Dietary Aide 3 indicated she was in the kitchen when a staff member approached her and told her something was wrong with Resident B. She went into the dining room and observed Resident B leaning to one side of his electric wheelchair. She indicated he was about to fall out. She called his name multiple times, but he did not respond. He had vomited and urinated on himself which was not like him. She activated the pull cord in the dining room, then went to the reception desk to have someone call the unit, but there was no one at the desk. She then went to the third floor Assisted Living Unit to get help. When the elevator opened, she saw CNA 4 and explained the situation. She asked her to come to the dining room. She asked LPN 2 to send someone to help CNA 4. LPN 2 began to call other nursing staff for assistance. Dietary Aide 3 and CNA 4 went to the dining room to assist Resident B. He was leaning all the way over and CNA 4 attempted to move him but could not. The CNA used a folded tablecloth, placed it around the resident across his chest, to pull him back up in the electric wheelchair. They could not get the safety belt about the resident. Resident B was confused, his hand hit the control on the electric wheelchair, and it propelled the wheelchair into a pillar in the dining room, almost hitting two residents sitting at	R 0352	**R 352 Clinical Documentation** **1 What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident B medical record reviewed by Clinical Director/Designee. Resident B was no longer a resident at the facility at the time of the citation. LPN 2 was provided One on One education in the form of coaching and counseling to ensure Complete and accurate documentation. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Clinical Director or designee to review the 24 hour report from EMR. Clinical Director or designee to review 24 hour shift report to ensure resident events are included in medical record. Direct Care Staff will be in-serviced on “Documentation in Medical Record” policy by Clinical Director/Designee on or before 03/8/2024, including but not limited to accurate and complete	03/08/2024

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	a table near the pillar. They ran to him and told him to take his hand off the control. He was not coherent. The CNA used the control, drove the resident to the elevator, and Dietary Aide 3 remained with her. When they got the resident to the third floor, LPN 2 checked the resident and found he was not responsive, his level of consciousness was in and out, and he was confused. He kept spitting up. He hit the control on the electric wheelchair and ran into the wall across from the elevator. CNA 4 was trying to get his hand off the control. They did get Resident B to his room, more staff responded, and assisted him to his bed. Dietary Aide 3 returned to the dining room after the resident had been transferred to his bed. The clinical record for Resident B was reviewed on 2/6/24 at 10:28 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side (weakness and paralysis from a stroke), chronic kidney disease, and malignant neoplasm of the prostate. The resident was admitted to the facility on 12/31/22 and passed away on 12/5/23. He was admitted to hospice care on 12/4/23. There was no documentation in the medical record to indicate the resident had any confusion, changes in level of consciousness or weakness between 12/1/23 and 12/5/23. During an interview, on 2/6/24 at 2:02 p.m., with the Director of Nursing for the skilled unit present, LPN 2 indicated Resident B was down in the dining room when Dietary Aide 3 came to the third floor and informed the nursing staff Resident B needed help. He was sliding off his chair. CNA 4		documentation and assessment in event of a resident change of condition. Direct Care Staff will be in-serviced on Facility Communication Tools and protocols by Clinical Director/Designee on or before 03/8/2024, including but not limited to accurate and complete documentation and assessment in event of a resident change of condition as well as response to change in condition. LPN 2 was provided One on One education in the form of coaching and counseling to ensure Complete and accurate documentation. **3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Direct Care Staff will be in-serviced on “Documentation in Medical Record” policy by Clinical Director/Designee on or before 03/8/2024, including but not limited to accurate and complete documentation of assessment and event for of a resident change of condition. Facility has reviewed facility communication protocols to ensure initial and back up systems are in place to assure documentation is complete and accurate for resident events.	

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	responded. LPN 2 did not respond because the information she received was that the resident was sliding out of his wheelchair. The resident was brought to the third-floor unit. He was weak and the staff helped him into bed. The resident had not been eating well, his blood sugar levels had been low, and he was just admitted to hospice. She checked his blood sugar and asked the resident if he wanted to go to the hospital, due to his increased weakness. The resident declined. The resident's son was contacted and declined having the resident sent out to the hospital. LPN 2 indicated she did assess Resident B and it was to be documented in the nursing note area of the record. During an observation and interview, on 2/6/24 at 2:08 p.m., LPN 2 reviewed the progress notes in the medical record. She was not able to show where the assessment had been documented. LPN 2 indicated she thought she had documented the assessment in the record. The Director of Nursing indicated there should have been documentation of the assessment in the record. During an interview, on 2/6/24 at 2:29 p.m., CNA 4 indicated Dietary Aid 3 came to the third-floor unit and retrieved her. Dietary Aide 3 told her Resident B was sliding out of his wheelchair and needed assistance to sit up. She was not aware of the full situation. When she arrived in the dining room, she had to use a tablecloth to help straighten him up in the chair. She indicated he was paralyzed on one side and was hard to maneuver. The safety belt was not assessable due to his position, the belt was behind him, and pushed down in the seat. They did get him to the third floor and the nurse assessed him. The nursing staff transferred Resident B to his bed and the nurse assessed him again. She indicated while in the dining room the		Direct Care Staff will be in-serviced on Facility Communication Tools by Clinical Director/Designee on or before 03/8/2024, including but not limited to accurate and complete documentation and assessment in event of a resident change of condition as well as response to change of condition. Clinical Director / Designee to review 24 hour reporting on all business days to ensure medical record are complete and accurate. **4 How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Medical Record Review Audit will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Medical Record Review Audit will occur daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. Facility has reviewed clinical reporting mechanisms to ensure initial and back up systems are in place to assure documentation is complete and accurate for resident events. Clinical Director will present results of Medical Record Review audit tool to the QAPI Committee	

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	resident did hit the control on the wheelchair and bumped into something. She had to hold his hand and drive the wheelchair with her other hand. He was not unconscious, but he was not "with it". She indicated she did not have time to pull out the cell phone and call the nurse to do an assessment prior to moving him. He had urinated on himself but did not vomit. He had spilled a drink on himself. She did not recall him hitting the wall on the unit. She should have had the nurse assess him prior to moving him from the dining room. A current facility policy, titled "Documentation in Medical Record," undated and received from the Assisted Living Director on 2/6/24 at 3:42 p.m., indicated "...Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy...Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred...." This citation relates to Complaint IN00425860.		Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	