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	11/15/2023

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 IN00420094 and IN00420266. This visit included the Investigation of Residential Complaint IN00421773. Complaint IN00420094 - Federal/state deficiencies related to the allegations are cited at F692. Complaint IN00420266 - No deficiencies related to the allegations are cited. Complaint IN00421773 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: November 14 and 15, 2023 Facility number: 001149 Provider number: 155618 AIM number: 200145500 Census Bed Type: SNF/NF: 26 SNF: 29 Residential: 76 Total: 131 Census Payor Type: Medicare: 13 Medicaid: 26 Other: 16 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The creation and submission of the 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 or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and **REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT** on or after 12/6/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Seib	Executive Director	12/04/2023

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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	Quality review was completed on November 28, 2023.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident was assessed to self-administer medications for 1 of 2 residents observed for medication administration. (Resident D) Findings include: During a random observation, on 11/14/23 at 9:51 a.m., a medication cup of pills was observed left on the bedside table. There were no qualified staff in the room at the time to observe the medication administration. Resident D was left to take her medication unattended. The record for Resident D was reviewed on 11/14/23 at 10:42 a.m. Diagnoses included, but were not limited to, Parkinson's disease, type 2 diabetes, and hypertension. Resident D did not have an order to self-administer medications in her record. Resident D did not have a self-administration assessment in her record to indicated she was able to safely self-administer medications. Resident D was not care planned to self-administer medications. During an interview, on 11/14/23 at 9:53 a.m.,	F 0554	**F 554 Resident Self-Admin Meds Clinically Appropriate** **1 What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident D assessed for self administration of medication. Resident D orders and Care Plan reviewed and updated as needed. Facility assessed all residents to determine if self administration of medication is clinically appropriate. Resident Orders and Care Plans updated as needed. **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 who self administer medications have the potential to be affected by the alleged deficient practice. A complete review of all residents to determine if self administration of medication is	12/06/2023

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	Resident D indicated staff did not always leave her medications with her and she was getting ready to take them. During an interview, on 11/14/23 at 9:57 a.m., the Assistant Director of Nursing indicated staff were not supposed to leave medications at the bedside without a nurse or QMA present. A current facility policy, titled "Administering Medications," dated as last revised in April of 2019 and received from the Director of Nursing on 11/14/23 at 3:30 p.m., indicated, "...Resident's may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely...." 3.1-11(a)		clinically appropriate was conducted on or before 12/1/2023. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 12/1/2023, including but not limited to the process to assess, care plan, and put orders in place when deemed clinically appropriate. **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 “Administering Medications” by DNS/Designee on or before 12/1/2023, including but not limited to the process to assess, care plan, and put orders in place when deemed clinically appropriate. Self-administration log created to track residents who are deemed clinically appropriate to self-administer medication. **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?** Self administration log will be audited daily by the Executive Director, Director of Nursing and/or designee to monitor compliance. Regular walking rounds will be utilized to ensure “Administering Medications”	

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			Policy is followed. Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. DNS will present results of Administration of Medication audit tool to the QAPI Committee 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.	
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 treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure a medication	F 0684	**F 684 Quality of Care** **1 What corrective actions**	12/06/2023

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	was administered per the physician's order for 1 of 2 residents observed for quality of care. (Resident B) Finding includes: During a random observation, on 11/14/23 at 10:16 a.m., Resident B was observed resting in bed. The resident had a Scopolamine transdermal patch (used to decrease secretions) behind his right ear. The patch had been dated 11/9/23. The record for Resident B was reviewed on 11/14/23 at 10:52 a.m. Diagnoses included, but were not limited to, paralytic syndrome following cerebrovascular disease (paralysis), dysphagia (difficulty swallowing), and persistent vegetative state. A physician's order, dated 12/31/20, indicated to administer a Scopolamine Patch 72 hour in the morning every three (3) days and remove per schedule. During an interview, on 11/14/23 at 10:22 a.m., LPN 1 indicated the patch was changed on the night shift and he was not sure how often the patch needed to be changed. He would check the medication order to see how often the patch needed to be changed. A current facility policy, titled "Administering Medications," dated as last revised in April of 2019 and received from the Director of Nursing on 11/14/23 at 3:30 p.m., indicated "...Medications are administered in accordance with prescriber orders, including any required time frame...." 3.1-37(a)		**will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident B orders and care plans reviewed for accuracy by DNS/Designee. The orders for resident B were modified to include daily task of monitoring the transdermal patch for placement and changed as ordered. This order was added to the Treatment Administration Tasks (TARs) for Direct Nursing. Facility audited all residents to identify other residents with orders for transdermal patches. Orders for monitoring transdermal patches were updated as needed. All transdermal patches have been added to the TAR for monitoring. **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 who are administered medication via transdermal patch have the potential to be affected by the alleged deficient practice. A complete review of residents with orders for transdermal patches was conducted on or before 12/1/2023. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on	

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			or before 12/1/2023, including but not limited to the placement and monitoring of transdermal patches. **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 “Administering Medications” by DNS/Designee on or before 12/1/2023, including but not limited to the placement and monitoring of transdermal patches. Orders for transdermal patches will include a Treatment task on TAR to check placement, monitor for date, and replace as ordered **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?** Treatment administration Record (TAR) and Medication administration record (MAR) is monitored daily for compliance. Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. DNS will present results of	

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			Administration of Medication audit tool to the QAPI Committee 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.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to ensure staff contacted the physician,	F 0692	**F 692 Nutrition/Hydration Status Maintenance**	12/06/2023

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	dietitian, or nurse practitioner to get an order for nutritional formula administration for 1 of 2 residents reviewed for gastronomy tube feedings. (Resident C) Finding includes: The record for Resident C was reviewed on 11/14/23 at 1:08 p.m. Diagnoses included, but were not limited to, malignant neoplasm of laryngeal cartilage (throat cancer), emphysema, and bipolar disorder. A care plan, initiated on 10/19/23, indicated Resident C was at risk for fluid imbalance due to chronic kidney disease and NPO (nothing to be given orally) status. The October Medication and Treatment Administration record did not have any documentation to show Resident C had received any meals or fluids via the gastronomy tube, for approximately 15 hours, from 10/17/23 beginning at 6:00 p.m., until a grievance was filed and investigated on 10/18/23 at 9:30 a.m. The resident admitted to the facility on 11/17/23 at 5:37 p.m. The hospital discharge orders did not have an order for enteral tube feeding (a way to deliver nutrition to the stomach or small intestine). This resulted in the resident not being provided any meals or fluids between 10/17/23 at 6:00 p.m., to 10/18/23 at 9:30 a.m. A facility document, titled "Report of Concern," with a concern date of October 17-October 18, 2023, between 6:00 p.m. to 9:00 a.m., indicated the		**1 What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident C was discharged home with the assistance of home health at the time of the citation. Facility assessed all residents currently receiving gastronomy tube feedings to ensure accuracy and compliance with orders. **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 receiving gastronomy tube feedings have the potential to be affected by the alleged deficient practice. A complete review of all residents receiving gastronomy tube feedings was conducted on or before 12/1/2023. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 12/1/2023, including but not limited to contacting the prescriber, the residents attending physician or the facility medical director if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences. Dietician	

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	grievance was reported by the family member of Resident C and indicated the resident had not been fed since she arrived in the facility. The findings documented on the form by facility staff indicated the resident did not have an order for a nutrition formula. The Nurse Practitioner and Registered Dietitian were notified on 10/18/23 at 9:30 a.m. The Registered Dietitian provided orders and the resident did receive the enteral nutrition after the order was received. During an interview, on 11/15/23 at 10:57 a.m., RN 2 indicated if a resident admitted to the facility with a gastronomy tube (a tube inserted into the stomach) and did not have orders, the physician needed to be contacted for nutritional orders. During an interview, on 11/15/23 at 12:26 p.m., the Director of Nursing indicated the policy for medication administration was all the facility had and it applied not only to inappropriate or excessive doses of medications but also applied if the order was absent. It applied to anyone receiving nutrition through a gastronomy tube. A current facility policy, titled "Administering Medications," dated as last revised in April of 2019 and received from the Director of Nursing on 11/14/23 at 3:30 p.m., indicated "...If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences...contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concern ...." This Federal Tag relates to Complaint IN00420094. 3.1-46(1)		can also be contacted in the case of Gastronomy tube feedings. Dietician and or designee consultant to review all gastronomy tube feedings prior to admission for order clarity. **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 “Administering Medications” by DNS/Designee on or before 12/1/2023, including but not limited to contacting the prescriber, the residents attending physician or the facility medical director if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences. Dietician can also be contacted in the case of Gastronomy tube feedings. Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. Ongoing monitoring of Diet orders including residents receiving All residents receiving gastronomy tube feedings is a part of our weekly Nutrition at Risk	

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	3.1-46(2)		Program (NAR) Dietician and or designee consultant to review all gastronomy tube feedings prior to admission for order clarity. **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?** Ongoing monitoring of All residents receiving gastronomy tube feedings is a part of our weekly Nutrition at Risk Program (NAR) Dietician and or designee consultant to review all gastronomy tube feedings prior to admission for order clarity. Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. DNS will present results of Administration of Medication audit tool to the QAPI Committee 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	

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			threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of			

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	abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview and record review, the facility failed to ensure documentation was correct in the resident record when the administration of a transdermal medication patch found on a resident was dated for 11/9/23 but	F 0842	**F 842 Resident Records – Identifiable Information** **1 What corrective actions will be accomplished for those residents found to have been**	12/06/2023

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	charted as being changed on 11/12/23 for 1 of 3 residents reviewed for documentation in the medical record. (Resident B) Finding includes: During a random observation, on 11/14/23 at 10:16 a.m., Resident B was observed resting in bed. The resident had a Scopolamine transdermal patch (used to decrease secretions) behind his right ear. The patch had been dated 11/9/23. The record for Resident B was reviewed on 11/14/23 at 10:52 a.m. Diagnoses included, but were not limited to, paralytic syndrome following cerebrovascular disease (paralysis), dysphagia (difficulty swallowing), and persistent vegetative state. A physician's order, dated 12/31/20, indicated to administer a Scopolamine Patch 72 hour in the morning every three (3) days and remove per schedule. The Medication Administration Record indicated the Scopolamine patch was documented as changed on 11/12/23 at 5:00 a.m. During an interview, on 11/14/23 at 10:22 a.m., LPN 1 indicated the patch was changed on the night shift and he was not sure how often the patch needed to be changed. During an interview, on 11/14/23 at 10:37 a.m., LPN 1 indicated the Scopolamine patch was not correctly signed off in the Medication Administration Record. A current facility policy, titled "Charting and Documentation," dated as last revised in July of		**affected by the alleged deficient practice?** Resident B medical record reviewed by DNS/Designee. The documentation error identified in the medical record for resident B was corrected. LPN 1 was provided One on One education as well as disciplinary action in the form of coaching and counseling to ensure accuracy of 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. A complete review of charting is completed daily via offsite audit. DNS or designee reviews the 24 hour report daily. Direct Care Staff will be in-serviced on “Charting and Documentation” by DNS/Designee on or before 12/1/2023, including but not limited to the requirement that documentation in the resident record be correct and how to report any documentation that may be inaccurate. LPN 1 was provided education as well as disciplinary action in the form of coaching and	

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	11/15/2023

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	2017 and received from the Director of Nursing on 11/14/23 at 3:30 p.m., indicated "...documentation in the medical record will be objective ...complete and accurate...." 3.1-50(a)(2)		counseling to ensure accuracy of 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 “Charting and Documentation” by DNS/Designee on or before 12/1/2023, including but not limited to the requirement that documentation in the resident record be correct and how to report any documentation that may not be correct. IDT to review and investigate any documentation issues reported. **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?** Treatment administration record and Medication administration record is monitored daily for compliance. Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. DNS will present results of	

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			Administration of Medication audit tool to the QAPI Committee 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.	
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00421773. This visit included the Investigation of Nursing Home Complaints IN00420094 and IN00420266. Complaint IN00421773 - No deficiencies related to the allegations are cited. Complaint IN00420094 - Federal/state deficiencies related to the allegations are cited at F692. Complaint IN00420266 - No deficiencies related to the allegations are cited. Survey dates: November 14 and 15, 2023 Facility number: 001149 Residential Census: 76 Majestic Care of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00421773.	R 0000	The creation and submission of the 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 or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and **REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT** on or after 12/6/2023.	

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	Quality review was completed on November 28, 2023.			