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

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE COMPL 11/15/	ETED		
	ROVIDER OR SUPPLIER			12999 N	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION
	REGULATORY OR	LISC IDENTIFYING INFORMATION		IAG	DEFICIENCE		DATE
F 0000 Bldg. 00	This visit was for the Home Complaints I This visit included to Residential Complaint IN00420 related to the allegar Complaint IN00420 the allegations are complaint IN00421 the allegat	int IN00421773.  1094 - Federal/state deficiencies tions are cited at F692.  1266 - No deficiencies related to ited.  1773 - No deficiencies related to ited.  1886 are cited.  1986 are cited.  1987 and 15, 2023  1987 and 15, 2023  1987 are cited.  1987 and 15, 2023  1988 are cited.  1988 are cited.	F 00	TAG 000	The creation and submission the Plan of Correction does not constitute an admission by thi provider of any conclusion set in the statement of deficiencie of any violation or regulation. provider respectfully requests 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.	of s forth s or This the	DATE
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	7	TITLE		(X6) DATE

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

(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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	A. BUILDING <u>00</u>			3) DATE SURVEY COMPLETED	
		155618	B. WING	j		11/15/	2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Quality review was 2023.	completed on November 28,					
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Adn §483.10(c)(7) The medications if the defined by §483.2 that this practice is Based on observation review, the facility assessed to self-adn residents observed for (Resident D)  Findings include:  During a random of a.m., a medication of on the bedside table in the room at the till administration. Resident medication unattend. The record for Resident D did not self-administer medication to diabetes, and hypertication.	dent D was reviewed on .m. Diagnoses included, but Parkinson's disease, type 2 tension.  thave an order to lications in her record.  thave a self-administration ecord to indicated she was dminister medications.  care planned to	F 055	4	F 554 Resident Self-Admin Meds Clinically Appropriate  1 What corrective actions will be accomplished for tho residents found to have been affected by the alleged deficient practice? Resident D assessed for administration of medication. Resident D orders and Care Freviewed and updated as need Facility assessed all residents to determine if self administration of medication is clinically appropriate. Resident Orders and Care Plans update 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 to potential to be affected by the alleged deficient practice. A complete review of all residents to determine if self	se n self Plan ded. s nt ed as	12/06/2023
	During an interview	y, on 11/14/23 at 9:53 a.m.,			administration of medication is	s	

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12/13/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/15/2023 155618 STREET 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 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Resident D indicated staff did not always leave clinically appropriate was her medications with her and she was getting conducted on or before 12/1/2023. ready to take them. Direct Care Staff will be in-serviced on "Administering During an interview, on 11/14/23 at 9:57 a.m., the Medications" by DNS/Designee on Assistant Director of Nursing indicated staff were or before 12/1/2023, including but not supposed to leave medications at the bedside not limited to the process to without a nurse or QMA present. assess, care plan, and put orders in place when deemed clinically A current facility policy, titled "Administering appropriate. Medications," dated as last revised in April of 2019 and received from the Director of Nursing on What measures will be put 11/14/23 at 3:30 p.m., indicated, "...Resident's may into place or what systemic self-administer their own medications only if the changes will be made to Attending Physician, in conjunction with the ensure that the deficient Interdisciplinary Care Planning Team, has practice will not recur? determined that they have the decision-making Direct Care Staff will be capacity to do so safely...." in-serviced on "Administering Medications" by DNS/Designee on 3.1-11(a) 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. 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

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be utilized to ensure "Administering Medications"

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designee to monitor compliance. Regular walking rounds will

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155618	B. WI	NG		11/15/	2023
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				I PENNSYLVANIA ST		
MAJESTI	C CARE OF CARM	IEL			L, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Policy is followed.  Audit Tool Administration Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 daweekly x4 weeks and monthly month and quarterly thereafter until compliance is achieved for two consecutive quarters.  DNS will present results of Administration of Medication at tool to the QAPI Committee 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 submitted to the QAPI committee overset by the ED for review and follows.	ne ays, x 3 or of udit ce taff	
F 0684 SS=D Bldg. 00	applies to all treating facility residents. Examples as facility must ensure treatment and care professional stand comprehensive per and the residents' Based on observation	a fundamental principle that ment and care provided to Based on the sessment of a resident, the e that residents receive in accordance with lards of practice, the erson-centered care plan,	F 06	584	F 684 Quality of Care 1 What corrective actions		12/06/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155618	B. WI	NG		11/15/	2023
		<u> </u>	_	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			N PENNSYLVANIA ST		
MAJESTI	IC CARE OF CARM	1EL			EL, IN 46032		
					I	1	ave.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	-	er the physician's order for 1 of			will be accomplished for tho		
		d for quality of care. (Resident			residents found to have been	n	
	B)				affected by the alleged		
	Finding includes:				deficient practice?  Resident B orders and ca	aro	
	Tinding includes.				plans reviewed for accuracy b		
	During a random of	oservation, on 11/14/23 at 10:16			DNS/Designee. The orders fo	-	
	-	as observed resting in bed. The			resident B were modified to	'	
		olamine transdermal patch			include daily task of monitorin	a	
	-	ecretions) behind his right ear.			the transdermal patch for	9	
	The patch had been				placement and changed as		
	The parent had even	11/7/25			ordered. This order was adde	ed to	
	The record for Resi	dent B was reviewed on			the Treatment Administration	,	
	11/14/23 at 10:52 a.m. Diagnoses included, but				Tasks (TARs) for Direct Nursi	na.	
		paralytic syndrome following			Facility audited all reside	-	
		ease (paralysis), dysphagia			to identify other residents with		
		ing), and persistent vegetative			orders for transdermal patche		
	state.				Orders for monitoring transde		
					patches were updated as nee		
	A physician's order,	, dated 12/31/20, indicated to			All transdermal patches have		
	administer a Scopol	amine Patch 72 hour in the			added to the TAR for monitori	ng.	
	morning every three	e (3) days and remove per					
	schedule.				2 How other residents		
					having the potential to be		
	~	y, on 11/14/23 at 10:22 a.m., LPN			affected by the same deficie		
	-	h was changed on the night			practice will be identified and		
		t sure how often the patch			what corrective action will be	е	
	_	ed. He would check the			taken?		
		see how often the patch			All residents who are		
	needed to be change	ed.			administered medication via		
					transdermal patch have the		
		olicy, titled "Administering			potential to be affected by the		
		l as last revised in April of			alleged deficient practice.		
		from the Director of Nursing on			A complete review of		
	-	m., indicated "Medications are			residents with orders for		
		ordance with prescriber orders,			transdermal patches was		
	including any requi	red time frame"			conducted on or before 12/1/2	2023.	
	2 1 27(-)				Direct Care Staff will be		
	3.1-37(a)				in-serviced on "Administering		
			1		Medications" by DNS/Designe	e on	

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

PRINTED: 12/13/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/15/2023
	ROVIDER OR SUPPLIEF		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				or before 12/1/2023, including not limited to the placement a monitoring of transdermal pat	and
				3 What measures will be 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/Design or before 12/1/2023, including not limited to the placement a monitoring of transdermal pathors or transdermal pathors will include a Treatm task on TAR to check placem monitor for date, and replace ordered	ee on g but and tches. ent lent,
				4 How corrective actions will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into plath a Treatment administration Record (TAR) and Medication administration record (MAR) monitored daily for compliant addit Tool Administration Medication will be utilized by Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 of weekly x4 weeks and monthly month and quarterly thereafted until compliance is achieved to two consecutive quarters.  DNS will present results	the cur  ce?  n n is se. n of the of days, y x 3 er for

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155618	B. WI	NG		11/15	/2023
NAME OF	PROVIDER OR SUPPLIEI	D.	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					N PENNSYLVANIA ST		
MAJEST	IC CARE OF CAR	MEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Administration of Medication a	audit	
					tool to the QAPI Committee		
					Monthly to review for complian	nce	
					and follow-up. Identified		
					noncompliance may result in s		
					reeducation and/or disciplinar	У	
					action.		
					If 100% threshold is not	_	
					achieved an action plan will be developed to achieve desired	е	
					threshold. Data will be submit	tad	
					to the QAPI committee overse		
					by the ED for review and follo		
					-,		
F 0692	483.25(g)(1)-(3)						
SS=D	Nutrition/Hydratio	n Status Maintenance					
Bldg. 00	§483.25(g) Assist	ted nutrition and hydration.					
	(Includes naso-ga	astric and gastrostomy					
	tubes, both percu	taneous endoscopic					
	1 -	percutaneous endoscopic					
	1	enteral fluids). Based on a					
		ehensive assessment, the					
	facility must ensu	re that a resident-					
	8483 25(g)(1) Ma	intains acceptable					
	,	tritional status, such as					
	· ·	t or desirable body weight					
		olyte balance, unless the					
	•	condition demonstrates					
	that this is not pos	ssible or resident					
	preferences indicate	ate otherwise;					
	\$493 2F(a)(2) la a	offered sufficient fluid intoke					
	,	offered sufficient fluid intake r hydration and health;					
	to maintain prope	i nyuralion anu nealin,					
	§483.25(g)(3) Is o	offered a therapeutic diet					
		utritional problem and the					
		der orders a therapeutic diet.					

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Based on interview and record review, the facility

failed to ensure staff contacted the physician,

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F 0692

Facility ID: 001149

Maintenance

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F 692 Nutrition/Hydration Status

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12/06/2023

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155618	B. WI	ING	<del></del> -	11/15	/2023
		<u>I</u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			N PENNSYLVANIA ST		
MAJEST	IC CARE OF CAR	MEL			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	practitioner to get an order for			1 What corrective actions	6	
		administration for 1 of 2			will be accomplished for the	se	
	residents reviewed for gastronomy tube feedings. (Resident C)				residents found to have bee	n	
					affected by the alleged		
					deficient practice?		
	Finding includes:				Resident C was dischar		
	The record for Resident C was reviewed on				home with the assistance of h		
					health at the time of the citation	on.	
	_	m. Diagnoses included, but were			Facility assessed all		
		gnant neoplasm of laryngeal			residents currently receiving		
	cartilage (throat car	ncer), emphysema, and bipolar			gastronomy tube feedings to		
	disorder.				ensure accuracy and complia	nce	
					with orders.		
	_	ed on 10/19/23, indicated					
		risk for fluid imbalance due to			2 How other residents		
		ease and NPO (nothing to be			having the potential to be		
	given orally) status				affected by the same deficie	nt	
					practice will be identified an	d	
		cation and Treatment			what corrective action will b	е	
		ord did not have any			taken?		
		how Resident C had received			All residents receiving		
		via the gastronomy tube, for			gastronomy tube feedings ha	ve	
		nours, from 10/17/23 beginning			the potential to be affected by	the	
	_	a grievance was filed and			alleged deficient practice.		
	investigated on 10/	18/23 at 9:30 a.m.			A complete review of all		
					residents receiving gastronon	-	
		ted to the facility on 11/17/23 at			tube feedings was conducted	on	
	5:37 p.m.				or before 12/1/2023.		
					Direct Care Staff will be		
	_	arge orders did not have an			in-serviced on "Administering		
		be feeding (a way to deliver			Medications" by DNS/Designe		
	nutrition to the stor	mach or small intestine).			or before 12/1/2023, including	g but	
					not limited to contacting the		
		resident not being provided			prescriber, the residents atter	-	
	I -	between 10/17/23 at 6:00 p.m.,			physician or the facility medic		
	to 10/18/23 at 9:30	a.m.			director if a dosage is believe		
					be inappropriate or excessive		
	-	t, titled "Report of Concern,"			resident, or a medication has	been	
	with a concern date	e of October 17-October 18,			identified as having potential		
	2023, between 6:00	p.m. to 9:00 a.m., indicated the			adverse consequences. Dieti	rian	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/15/2023 155618 STREET 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 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE grievance was reported by the family member of can also be contacted in the case Resident C and indicated the resident had not of Gastronomy tube feedings. been fed since she arrived in the facility. The Dietician and or designee findings documented on the form by facility staff consultant to review all indicated the resident did not have an order for a gastronomy tube feedings prior to nutrition formula. The Nurse Practitioner and admission for order clarity. Registered Dietitian were notified on 10/18/23 at 9:30 a.m. The Registered Dietitian provided orders What measures will be put and the resident did receive the enteral nutrition into place or what systemic after the order was received. changes will be made to ensure that the deficient During an interview, on 11/15/23 at 10:57 a.m., RN practice will not recur? 2 indicated if a resident admitted to the facility Direct Care Staff will be with a gastronomy tube (a tube inserted into the in-serviced on "Administering stomach) and did not have orders, the physician Medications" by DNS/Designee on needed to be contacted for nutritional orders. or before 12/1/2023, including but not limited to contacting the During an interview, on 11/15/23 at 12:26 p.m., the prescriber, the residents attending Director of Nursing indicated the policy for physician or the facility medical medication administration was all the facility had director if a dosage is believed to and it applied not only to inappropriate or be inappropriate or excessive for a excessive doses of medications but also applied if resident, or a medication has been the order was absent. It applied to anyone identified as having potential receiving nutrition through a gastronomy tube. adverse consequences. Dietician can also be contacted in the case A current facility policy, titled "Administering of Gastronomy tube feedings. Medications," dated as last revised in April of Audit Tool Administration of 2019 and received from the Director of Nursing on Medication will be utilized by the 11/14/23 at 3:30 p.m., indicated "...If a dosage is Executive Director, Director of believed to be inappropriate or excessive for a Nursing and/or designee to resident, or a medication has been identified as monitor compliance daily x5 days, having potential adverse consequences for the weekly x4 weeks and monthly x 3 resident or is suspected of being associated with month and quarterly thereafter adverse consequences...contact the prescriber, until compliance is achieved for the resident's Attending Physician or the facility's two consecutive quarters. Medical Director to discuss the concern ...." Ongoing monitoring of Diet orders including residents This Federal Tag relates to Complaint IN00420094. receiving All residents receiving gastronomy tube feedings is a part

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3.1-46(1)

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of our weekly Nutrition at Risk

If continuation sheet

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

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155618	B. W	ING		11/15	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			N PENNSYLVANIA ST		
MAJEST	IC CARE OF CAR	MEI			EL, IN 46032		
W// VOLOT		VICE		O/ ti tivii			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-46(2)				Program (NAR)		
					Dietician and or designed	Э	
					consultant to review all		
					gastronomy tube feedings prid	or to	
					admission for order clarity.		
					4 How corrective actions		
					will be monitored to ensure	the	
					deficient practice will not red	cur	
					i.e., what quality assurance		
					program will be put into place	:e?	
					Ongoing monitoring of Al		
					residents receiving gastronom	ıy	
					tube feedings is a part of our		
					weekly Nutrition at Risk Progr	am	
					(NAR)		
					Dietician and or designed	Э	
					consultant to review all		
					gastronomy tube feedings prid	or to	
					admission for order clarity.		
					Audit Tool Administration	n of	
					Medication will be utilized by t	he	
					Executive Director, Director of	f	
					Nursing and/or designee to		
					monitor compliance daily x5 d	•	
					weekly x4 weeks and monthly		
					month and quarterly thereafte	r	1
					until compliance is achieved for	or	
					two consecutive quarters.		
					DNS will present results		
					Administration of Medication a	audit	
					tool to the QAPI Committee		
					Monthly to review for complian	nce	1
					and follow-up. Identified		
					noncompliance may result in		
					reeducation and/or disciplinar	У	
					action.		
					If 100% threshold is not		
					achieved an action plan will be	е	
1	I		1		developed to achieve desired		I

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155618	B. WI	NG		11/15/	2023
	PROVIDER OR SUPPLIER		•	12999 N	NDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.7 Resident Records §483.20(f)(5) Resi (i) A facility may no is resident-identifiated ii) The facility may resident-identifiable accordance with a agent agrees not to information exceptitiself is permitted to §483.70(i) Medica §483.70(i)(1) In accordance with a gent agrees not to information exceptitiself is permitted to §483.70(i)(1) In accordance with a gent agrees in the facility must maint each resident that (i) Complete; (ii) Accurately doccomplete; (iii) Readily access (iv) Systematically §483.70(i)(2) The confidential all information and information in the records, exception to the individual representative who law; (ii) Required by Lagrangian in the confidential information in the records, exception in the individual representative who law; (iii) Required by Lagrangian in the confidential information in the records, exception in the records, exception in the individual representative who law; (iii) Required by Lagrangian in the confidential in the records, exception in the records, exception in the records of the facility of the individual representative who law; (iii) Required by Lagrangian in the confidential and the records of the facility of the individual representative who law; (iii) Required by Lagrangian in the confidential and the records of the facility of the confidential and the records of the facility of the confidential and the records of the facility of the confidential and the records of the facility of the confidential and the records of the facility of the confidential and the records of the facility of the confidential and the records of the facility of the facility of the confidential and the con	70(i)(1)-(5)  - Identifiable Information ident-identifiable information. Out release information that able to the public. It is to an agent only in a contract under which the iso use or disclose the it to the extent the facility iso do so.  I records. It is is is is is incordance with accepted lards and practices, the ain medical records on are-  umented; is is is is incordance in the iso or storage method of out when release isal, or their resident ere permitted by applicable is incordance.		TAG	threshold. Data will be submitt to the QAPI committee overse by the ED for review and follows:	ed en	DATE
	compliance with 4	5 CFR 164.506;					
	(iv) For public hea	Ith activities, reporting of					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NOT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 00  155618  EXAMPLE OF CONSTRUCTION A. BUILDING 00  B. WING			(X3) DATE SURVEY COMPLETED 11/15/2023			
	PROVIDER OR SUPPLIE			12999 I	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	, 		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	oversight activitie proceedings, law organ donation proportion to coroners, modirectors, and to a health or safety a compliance with 4 \$483.70(i)(3) The medical record in destruction, or un \$483.70(i)(4) Medical record for the contained for a minor, 3 reaches legal age \$483.70(i)(5) The contained in Sufficient information and the complete services provided (iv) The results of screening and resident and re	facility must safeguard formation against loss, authorized use.  dical records must be dime required by State law; or in the date of discharge requirement in State law; or is years after a resident a under State law.  medical record must mation to identify the de resident's assessments; densive plan of care and figure and preadmission sident review evaluations and conducted by the State; urse's, and other licensed					
	Based on observation review, the facility was correct in the review.	on, interview and record failed to ensure documentation esident record when the transdermal medication patch	F 08	842	F 842 Resident Records – Identifiable Information  What corrective actions will be accomplished for tho		12/06/2023

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found on a resident was dated for 11/9/23 but

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residents found to have been

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155618	B. W	ING		11/15	/2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			N PENNSYLVANIA ST		
ΜΔ ΙΕςΤ	IC CARE OF CAR	MEI			EL, IN 46032		
IVIAJEST		WILL		CARIVIL	-L, IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nanged on 11/12/23 for 1 of 3			affected by the alleged		
		for documentation in the			deficient practice?		
	medical record. (Re	esident B)			Resident B medical reco		
					reviewed by DNS/Designee.		
	Finding includes:				documentation error identified		
					the medical record for resider	nt B	
	_	bservation, on 11/14/23 at 10:16			was corrected.		
	·	as observed resting in bed. The			LPN 1 was provided One	e on	
	_	polamine transdermal patch			One education as well as		
		ecretions) behind his right ear.			disciplinary action in the form	of	
	The patch had beer	1 dated 11/9/23.			coaching and counseling to		
					ensure accuracy of		
		ident B was reviewed on			documentation.		
		a.m. Diagnoses included, but					
		, paralytic syndrome following			2 How other residents		
		sease (paralysis), dysphagia			having the potential to be		
	(difficulty swallow	ring), and persistent vegetative			affected by the same deficie		
	state.				practice will be identified an		
					what corrective action will b	е	
		r, dated 12/31/20, indicated to			taken?		
	_	plamine Patch 72 hour in the			All residents have the		
		ee (3) days and remove per			potential to be affected by the	!	
	schedule.				alleged deficient practice.		
					A complete review of		
		dministration Record indicated			charting is completed daily via	3	
		atch was documented as			offsite audit.		
	changed on 11/12/2	25 at 5:00 a.m.			DNS or designee review	s the	1
	D	11/14/22 + 10.22			24 hour report daily.		
	_	w, on 11/14/23 at 10:22 a.m., LPN			Direct Care Staff will be		
	_	ch was changed on the night			in-serviced on "Charting and		
		ot sure how often the patch			Documentation" by DNS/Des	•	
	needed to be chang	ged.			on or before 12/1/2023, include	-	
	Duning and interest	v. on 11/14/22 at 10:27 I DNI			but not limited to the requirem		
	_	w, on 11/14/23 at 10:37 a.m., LPN			that documentation in the res	iaent	
		polamine patch was not			record be correct and how to		
		f in the Medication			report any documentation tha	ι	
	Administration Red	cora.			may be inaccurate.		
	A	alian titled IICh antina a 1			LPN 1 was provided		1
		olicy, titled "Charting and			education as well as disciplination	-	
	Documentation," d	ated as last revised in July of	1		action in the form of coaching	and	

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Î Î		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155618	A. BUILDING B. WING	00	COMPLETED 11/15/2023			
		100010			11,10,2020			
NAME OF P	ROVIDER OR SUPPLIER	L		ADDRESS, CITY, STATE, ZIP COD				
ΜΔ ΙΕςΤ	IC CARE OF CARM	1 <b>-</b> 1		N PENNSYLVANIA ST EL, IN 46032				
MAJEOT			- OAKWII					
(X4) ID		UMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION		(X5)				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION	TAG		DATE			
		rom the Director of Nursing on		counseling to ensure accuract documentation.	y or			
	11/14/23 at 3:30 p.m., indicated "documentation in the medical record will be objectivecomplete			documentation.				
	and accurate"	a win so objective incomplete		3 What measures will be	out			
			into place or what systemic	,				
	3.1-50(a)(2)			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/Desi	~			
				on or before 12/1/2023, including				
				but not limited to the requirement that documentation in the resident				
				record be correct and how to	dent			
				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 red	cur			
				i.e., what quality assurance				
				program will be put into place				
				Treatment administration	1			
				record and Medication				
				administration record is monit	brea			
				daily for compliance.  Audit Tool Administration	n of			
				Medication will be utilized by t				
				Executive Director, Director of				
				Nursing and/or designee to				
				monitor compliance daily x5 d	ays,			
				weekly x4 weeks and monthly	-			
				month and quarterly thereafte	r			
				until compliance is achieved for	or			
				two consecutive quarters.				

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DNS will present results of

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	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER  155618		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/15/2023			
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF CARMEL			12999	STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE			
				Administration of Medicatio tool to the QAPI Committee Monthly to review for comp and follow-up. Identified noncompliance may result reeducation and/or disciplinaction.  If 100% threshold is not achieved an action plan will developed to achieve desir threshold. Data will be subto the QAPI committee over by the ED for review and for	e iliance in staff inary ot il be red imitted irseen			
R 0000								
Bldg. 00	Complaint IN00421 Investigation of Nu IN00420094 and IN Complaint IN00422 the allegations are of Complaint IN00420 related to the allegations are of Complaint IN00420 the allegations are of Survey dates: Nove Facility number: 00 Residential Census: Majestic Care of Ca compliance with 41	773 - No deficiencies related to ited.  1094 - Federal/state deficiencies tions are cited at F692.  1266 - No deficiencies related to ited.  1149	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.		s not this set forth cies or on. This sts the the			

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

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155618	B. WING			11/15/2023	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Quality review was 2023.	completed on November 28,					

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