STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155247	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Southport	8549 S Madison Ave Indianapolis, IN 46227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35099 Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity for 1 of 12 residents observed during the noon meal. Staff did not sit to assist residents with their meal. (Resident 60) Finding includes: During a dining observation on 10/7/24 at 12:10 p.m., Unit Manager (UM) 2 assisted Resident 60 with the noon meal while standing over Resident 60. UM 2 was not observed to be seated. During an interview on 10/7/24 at 12:48 p.m., the Director of Nursing (DON) indicated that staff should be sitting at eye level but not standing while assisting residents with meals. During an interview on 10/7/24 at 12:50 p.m., UM 2 indicated staff should be sitting at eye level when assisting residents with meals. On 10/8/24 at 8:50 a.m., Resident 60's clinical record was reviewed. The diagnosis included but was not limited to, Alzheimer's disease. A Quarterly Minimum Data Set (MDS) assessment, dated 9/18/24, indicated the resident had severe cognitive impairment and required extensive assistance with eating. On 10/7/24 at 12:56 p.m., the DON provided a copy of a policy titled Dignity, revised on 1/2/24, and indicated it was the policy currently being followed by the facility. A review of the policy indicated it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality. 3.1-3(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 38466 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for 1 of 4 residents reviewed for environment. Call lights were not within reach. (Resident 8) Findings include: During an observation on 10/7/24 from 11:47 a.m. to 11:55 a.m., Resident 8 was observed resting in bed. Resident 8's call light was observed mounted to the wall between Resident 8's bed and the roommate's bed. The call light cord was attached to the wall mount and the other end of the cord was observed lying on the floor behind Resident 8's headboard. The call light was out of reach of Resident 8. During an interview at that time, Resident 8 indicated she was not able to find her call light. During an interview on 10/7/24 at 11:58 a.m., RN 3 indicated all call lights were to be kept within reach of the resident. During an observation on 10/8/24 from 9:13 a.m. to 9:20 a.m., Resident 8 was observed resting in bed. Resident 8's call light was observed mounted to the wall between Resident 8's bed and the roommate's bed. The call light cord was attached to the wall mount and the other end of the cord was observed lying on the floor behind Resident 8's headboard. The call light was out of reach of Resident 8. During an interview on 10/8/24 at 9:22 a.m., Unit Manager 2 indicated Resident 8's call light was supposed to be kept within reach of the resident. On 10/9/24 at 3:00 p.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, history of falling and anemia. The Annual Minimum Data Set (MDS) assessment, dated 8/22/24, indicated Resident 8 was moderately cognitively intact. Resident 8's care plan, revised on 6/13/24, indicated the resident was at risk for falls. Interventions, dated 10/16/23, included keep call light .within reach. During an interview on 10/10/24 at 3:05 p.m., the Director of Nursing Services indicated call lights were to be kept within reach of the resident. On 10/10/24 at 8:30 a.m., the Director of Nursing Services provided a copy of the Resident Rights policy, dated 12/12/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, . Safe environment: the resident has a right to a safe .environment . On 10/10/24 at 8:30 a.m., the Director of Nursing Services provided a copy of the Call Lights policy, dated 12/12/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, .Staff will ensure the call light is within reach of resident .The call system will be accessible to residents while in their bed . (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(v)(1)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38466 Based on interview and record review, the facility failed to ensure that written Notice of Transfer and Discharge was provided to the resident and the resident's representative for 1 of 6 residents reviewed for transfers and discharges. (Resident 10) Finding includes: On 10/10/24 at 9:57 a.m., Resident 10's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes, COPD (Chronic Obstructive Pulmonary Disease, a lung disease that makes it difficult to breathe), heart disease, and risk for falls. Resident 10's face sheet identified a family member as the resident's representative. The clinical record's Census tab indicated Resident 10 had been transferred to the hospital emergency department on 5/23/24. A progress note, dated 5/23/24 at 2:52 p.m., indicated [Resident 10] returned from ED [Emergency Department] . The clinical record lacked documentation that the written Notice of Transfer and Discharge was provided to the resident and the resident's representative for the facility-initiated hospital transfer on 5/23/24. During an interview on 10/10/24 at 1:15 p.m., Unit Manager 2 indicated Resident 10 was transferred to the hospital emergency department on 5/23/24. The facility was unable to provide verification that the written Notice of Transfer and Discharge was provided to the resident and the resident's representative for the facility-initiated hospital transfer on 5/23/24. On 10/11/24 at 8:10 a.m., the Administrator provided a copy of the Transfer & Discharge policy, dated 12/12/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, . Emergency Transfers/Discharges: initiated by the facility for medical reasons to an acute care setting such as a hospital .provide a notice of transfer and the facility's bed hold policy to the resident and representative . ombudsman .The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand . 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45292 Based on interview and record review, the facility failed to ensure written bed hold notifications were provided to the resident and to the resident's representative for 1 of 6 residents reviewed for transfers. (Resident 10). Finding includes: On 10/10/24 at 1:15 p.m., Resident 10's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), heart failure, and type 2 diabetes. The clinical record's census tab indicated Resident 10 had been transferred to the hospital emergency department on 5/23/24. A progress note, dated 5/23/24 at 2:52 p.m., indicated [Resident 10] returned from ED [Emergency Department] . The clinical record lacked documentation that the written bed hold notification was provided to Resident 10 or to the resident's representative for the hospital transfer on 5/23/24. During an interview on 10/10/24 at 1:15 p.m., Unit Manager 2 indicated Resident 10 was transferred to the hospital emergency department on 5/23/24. The facility lacked verification that the written bed hold notification was given to the resident and their representative. On 10/11/24 at 8:10 a.m., the Administrator provided a copy of the [NAME] Care Bed Hold policy, dated 1/2/24, and indicated it was the current policy in use by the facility. A review of the policy indicated that the resident and the resident's representative would be provided the bed hold policy at the time of the hospital transfer or therapeutic leave, or would be provided written notice within 24 hours for an emergency transfer of the resident, and that the facility would keep a signed and dated copy of the bed-hold notice information given to the resident and /or resident representative in the resident's file. 3.1-12(a)(25) 3.1-12(a)(26)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36746 Based on observation, interview, and record review, the facility failed to develop a comprehensive person centered care plan for a resident who refused care for 1 of 1 residents reviewed for Activities of Daily Living. (Resident 62) Finding includes: On 10/7/24 at 10:16 a.m., observed Resident 62 in his room. The resident was in bed and awake. A strong foul smell was noted inside the room. On 10/8/24 at 10:22 a.m., observed Resident 62 in his room. A strong foul odor was noted in the residents room. On 10/9/24 at 9:00 a.m., observed Resident 62 in his room. A strong foul odor was noted in the resident's room. On 10/7/24 at 11:00 a.m., the clinical record of Resident 62 was reviewed. The diagnosis included but was not limited to, morbid (severe) obesity. A care plan, dated 7/19/24, indicated Resident 62 required assistance with activities of daily living secondary to diagnosis of acute on chronic respiratory failure, heart failure, morbid obesity, decreased mobility. The interventions included, but was not limited to, requires the assistance of one staff. The clinical record lacked a person centered care plan that included the refusal of showers and refusal of other care. During an interview on 10/9/24 at 9:10 a.m., the Director of Nursing indicated Resident 62 refused care, including showers. On 10/9/24 at 9:30 a.m., the DON indicated a care plan for Resident 62's refusal of care was not available. On 10/10/24 at 9:49 a.m., the DON provided a policy titled Comprehensive Care Plan, dated 1/2/24, and indicated it was the current policy being used by the facility. A review of the policy indicated, .3. The comprehensive care plan will describe, at the minimum, the following: .b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. 3.1-35(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 38466 Based on interview and record review, the facility failed to ensure weekly weights were recorded in the clinical record and failed to monitor a resident's weight for significant weight changes for 1 of 3 residents reviewed for nutrition. (Resident 23) Finding includes: On 10/8/24 at 3:14 p.m., Resident 23's clinical record was reviewed. The diagnoses included, but were not limited to, Huntington's Disease, diabetes, dementia, asthma, and abnormal weight loss. The Registered Dietician assessment, dated 8/29/24, indicated Resident 23 had a history of abnormal weight loss and required assistance with meals. The clinical record lacked additional dietician evaluations or dietary notes. Physician orders, dated 9/13/24 with no end date noted, indicated weekly weights. Resident 23's care plan, revised on 10/7/24, indicated Resident 23 had a potential nutritional risk related to abnormal weight loss and malnutrition. The care plan goal included will not exhibit significant weight loss. Interventions initiated on 9/25/24 included weights as ordered/indicated, notify MD [physician] of significant weight changes .Registered Dietician to evaluate and make diet changes/recommendations as needed. Resident 23's September 2024 Treatment Administration Record (TAR) indicated weekly wt [weight] one time a day every Friday, start date: 9/13/24. A review of the TAR record indicated clinical staff signed the document on 9/13/24, 9/20/24, and 9/27/24, which signified the weekly weights were obtained. The TAR record lacked the actual weekly recorded weight amounts for those specific dates. Resident 23's Vital Record weight report indicated the following: - On 8/26/24 at 1:19 p.m., Resident 23's weight was 141.4 pounds. - On 9/2/24 at 1:07 p.m., Resident 23's weight was 141.0 pounds; a 0.4-pound loss between 8/26/24 and 9/2/24. - On 10/1/24 at 7:55 a.m., Resident 23's weight was 151.8 pounds; a 10.8-pound weight gain between 9/2/24 and 10/1/24. - On 10/2/24 at 12:48 p.m., Resident 23's weight was 127.2 pounds, a 24.6-pound weight loss between 10/1/24 and 10/2/24. The clinical record lacked documentation that weekly weights were recorded as prescribed by the physician. The clinical record lacked documentation that the physician was notified of the significant weight changes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation that monitoring for the weight fluctuations had been identified and corresponding interventions were implemented. During an interview on 10/9/24 at 8:45 a.m., Qualified Medication Aide (QMA) 4 indicated resident weights were to be recorded in the Vital Record weight report tab in the electronic clinical record. During an interview on 10/9/24 at 10:45 a.m., the Assistant Director of Nursing Services (ADNS) indicated Resident 23's clinical record indicated the staff signatures on the TAR record reflected the weekly weights had been taken. However, the actual weight amounts had not been recorded in the clinical record. The ADNS indicated perhaps there was a problem with the weight scale machine which caused the weight fluctuations for 10/1/24 and 10/2/24 recorded weights. The record lacked evidence of any updated weight monitoring or interventions for Resident 23. During an interview on 10/11/24 at 10:20 a.m., the Director of Nursing Services indicated the weekly weights should have had data entered into the clinical record. All documentation entered into the record was to be accurate. No additional assessments or interventions were implemented as a result of Resident 23's weight changes. On 10/10/24 at 9:55 a.m., the Director of Nursing Services provided a copy of the Nutrition Management policy, dated 12/12/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, .the resident's nutritional care .will be reviewed .as needs/interventions change .at least monthly to provide nutrition assessment/recommendations for those residents determined to be at risk . On 10/11/24 at 10:20 a.m., the Regional Clinical Consultant provided a copy of the Physician Orders policy, dated 12/12/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, . to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality .documentation .will be maintained in the resident's clinical record . 3.1-46(a)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45292 Based on interview and record review, the facility failed to document the drug disposition records for 2 of 2 records reviewed for discharged residents. (Resident 77, Resident 78) Findings include: 1. On 10/10/24 at 9:45 a.m., the clinical record of Resident 77 was reviewed. The diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe) and type 2 diabetes. A physician's order summary report of medications, dated for active orders as of 9/1/24, included but were not limited to: - acetaminophen 500 mg (milligrams) for pain, fever, or headache - cholecalciferol (vitamin D3) 1,000 units for vitamin deficiency - insulin glargine subcutaneous solution 20 units injection for diabetes - insulin lispro subcutaneous solution with a sliding scale (dosage varied based on blood sugar at time of administration) for diabetes - metformin hydrochloride 500 mg for diabetes - sertraline hydrochloride 50 mg for depression - sodium chloride 1,000 mg for hyponatremia (low sodium levels) - solifenacin succinate 5 mg for bladder spasm A progress note, dated 9/1/24 at 5:20 a.m., indicated that resident had passed away at facility. Resident 77's clinical record lacked documentation of medications being sent back to the pharmacy or destroyed. 2. On 10/10/24 at 10:00 a.m., the clinical record of Resident 78 was reviewed. The diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe) and unspecified heart failure. A physician's order summary report of medications, dated for active orders as of 6/1/24, included but were not limited to: - acetaminophen 650 mg for general discomfort (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- atorvastatin calcium 40 mg for high cholesterol - benztropine mesylate 1 mg for neurologic/mood - Combivent Respimat inhalation 20-100 mcg (micrograms) for shortness of breath/COPD - Eliquis 5 mg for blood thinner - fluticasone propionate nasal spray 50 mcg for allergies - gavilax powder 17 gm (gram) for constipation - melatonin 3 mg for other sleep disorders - metoprolol succinate 25 mg for hypertensive heart disease - paliperidone 1.5 mg for schizophrenia - paliperidone palmitate IM (intramuscular) suspension 234 mg/1.5 mL (milliters) for schizophrenia - saline nasal solution for sinus congestion - sennosides docusate sodium 8.6-50 mg for constipation A progress note, dated 7/12/24, indicated Resident 78 was discharged from facility with all medications and belongings. Resident 78's clinical record lacked documentation of a medication release form listing all medications that were sent home with the resident or resident's representative. During an interview on 10/10/24 at 9:17 a.m., the Director of Nursing (DON) indicated that they lacked documentation for the drug dispositions for Resident 77 and Resident 78. On 10/11/24 at 10:35 a.m., the Regional Clinical Consultant (RCC) provided a policy titled Medication Returns, Credits, and Destruction, dated 2/1/18, and indicated it was the current policy being used by the facility. A review of the policy indicated that all items returned to the pharmacy must be logged on a medication return form; the facility was to send the white and yellow copies of the triplicate forms, and they were to keep the pink copy at the facility for their records. 3.1-25(o) 3.1-25(s)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36746 Based on observation, interview, and record review, the facility failed to ensure a current menu was posted for 1 of 1 meal observed. Posted menus were incorrect. Finding includes: During an observation on 10/7/24 at 12:33 p.m., a posted menu was observed on the entry way of the main dining room. The posted menu indicated it was week 4. The menu indicated today's lunch consisted of turkey, carrots, mashed potatoes, and a roll. On 10/7/24 at 12:45 p.m., observed a menu posted on the wall on the entrance to the B wing. The posted menu indicated it was week 3. The menu indicated today's lunch on 10/7/24 consisted of cheesy ham and macaroni, spinach, corn bread, and pineapple tidbits. On 10/7/24 from 12:33 p.m. until 1:00 p.m., observed the facility staff serving the main dining room trays for the noon meal. The meal received by the residents included, brochette chicken, parmesan noodles, green beans, and a dinner roll. During an interview on 10/7/24 at 12:50 p.m., the Staff Scheduler indicated the posted menu's should reflect what was currently being served. During an interview on 10/7/24 at 1:09 p.m., the Dietary Manager indicated the current posted menu should have indicated, day two of week one. The posted menu's should have been changed on 10/5/24. On 10/9/24 at 9:15 a.m., during Resident Council meeting, Resident 48 indicated the residents never knew what they were having for meals until they receive their meal tray. Resident 48 indicated the posted menu was always wrong. On 10/7/24 at 1:43 p.m., the Executive Director provided a policy titled Menus, dated 10/2022, and indicated it was the current policy being used by the facility. A review of the policy indicated .6. Menus will be served as written, unless a substitution is provided in response to preference . 8. Menus will be posted in the Dining Services department, dining rooms and resident/patient care areas . 3.1-20(k)