STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Carmel	12999 N Pennsylvania St Carmel, IN 46032

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the State Long-Term Care Ombudsman was notified after a resident was discharged to the hospital for 2 of 3 residents reviewed for hospitalization. (Resident 13 and 6)Findings include:1. The clinical record for Resident 13 was reviewed on 7/22/25 at 1:45 p.m. The diagnoses included, but were not limited to, fracture of the right femur, dementia, and anxiety.The clinical record indicated Resident 13 was discharged to the hospital after a fall on 6/12/25 and was readmitted back into the facility on 6/19/25.A document, titled Admission/Discharge To/From Report, dated 6/1/25 to 6/30/25 did not have Resident 13 listed as a discharged resident in the month of June.2. The clinical record for Resident 6 was reviewed on 7/23/25 at 1:21 p.m. The diagnoses included, but were not limited to, hypotension (low blood pressure), dementia, and traumatic subdural hemorrhage.The clinical record indicated Resident 6 was discharged to the hospital on 2/16/25 and was readmitted back into the facility on 2/18/25.A document, titled Admission/Discharge To/From Report, dated 2/1/25 to 2/30/25 did not have Resident 6 listed as a discharged resident in the month of February.The clinical record also indicated Resident 6 was discharged to the hospital on 6/21/25 and was readmitted back into the facility on 6/23/25.A document, titled Admission/Discharge To/From Report, dated 6/1/25 to 6/30/25 did not have Resident 6 listed as a discharged resident in the month of June.During an interview, on 7/23/25 at 2:50 p.m., the Social Service Director (SSD) indicated Resident 13, and Resident 6 were not included on the discharged residents list for the month of June. During an interview, on 7/23/25 at 3:12 p.m., the SSD indicated Resident 13 and 6 were both a bed hold and not a discharge, therefore, neither were included on the discharge list for the Ombudsman to be notified.A current document, titled Family of Social Service Administration, last updated October 2024, indicated .CMS requires nursing facilities to notify the Long-Term Care (LTC) Ombudsman of the majority of residents' transfers and discharges .When a resident is transferred on an emergency basis to an acute care facility and expected to return, the SLTCO must be notified. Information from facilities regarding emergency transfers should be provided in a monthly list to the SLTCO, which should include residents' names, dates of transfer, facilities to which residents were transferred, and reasons for the transfers A current facility policy, titled TRANSFER NOTICE, dated 1/2/24 and received from the Executive Director on 7/28/25 at 9:00 a.m., indicated .A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.3.1-12(a)(6)(A)(iv)

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a Preadmission Screening and Record Review (PASARR) was completed after new psychotropic medications were prescribed for 2 of 3 residents reviewed for PASARR. (Resident 35 and 13)Findings include:1. The clinical record for Resident 35 was reviewed on 7/22/25 at 2:52 p.m. The diagnoses included, but were not limited to, major depressive disorder, insomnia, and heart failure. A notice of PASARR level II outcome, dated 10/26/22, indicated Resident 35 had no mental health medications and if there was a significant change in physical or mental health, a new Level II evaluation would be needed. The nursing facility must submit an updated Level I screening to see if a further PASARR evaluation was needed. A physician's order, dated 7/1/25, indicated to administer Sertraline HCL (an antidepressant medication) 25 milligrams (mg) 3 tablets one time per day for depression. There was not another PASARR in the electronic medical record. During an interview, on 7/23/25 at 10:23 a.m., the Social Services Director (SSD) indicated another PASARR should have been completed if the resident was started on Sertraline. During an interview, on 7/23/25 at 2:48 p.m., the SSD indicated the facility would resubmit a PASARR if a new mental health medication was prescribed. The most recent PASARR did not include Sertraline. 2. The clinical record for Resident 13 was reviewed on 7/22/25 at 1:45 p.m. The diagnoses included, but were not limited to, anxiety disorder, bipolar disorder, and schizophrenia. A notice of PASARR level I outcome, dated 9/27/24, indicated Resident 13 was not currently prescribed and had not been prescribed any medication for anxiety within the past six months. The document also indicated, if a status change occurred, then an updated Level I must be submitted by the nursing facility to report the change. A psychiatric visit note, dated 5/6/25, indicated Ativan (an anxiety medication) would be prescribed after staff had reported Resident 13 was experiencing increased anxiousness, paranoia, and tearfulness. A physician's order, dated 5/6/25, indicated Resident 13 was prescribed Ativan 0.5 milligrams, two times a day, for anxiety. A care plan, dated 5/7/25, indicated Resident 13 was at risk for adverse side effects related to the use of antianxiety medications. An updated Level I PASSAR which included the addition of Ativan was not found in the electronic health record. During an interview, on 7/23/25 at 2:51 p.m., the SSD indicated a new Level I PASSAR would need submitted after a mental health medication change. A new Level I had not been submitted after the (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addition of Ativan for Resident 13. A current facility policy, titled PASARR, dated as last revised on 4/17/25, and received from the Executive Director on 7/28/25 at 9:00 a.m., indicated .To coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services in the most integrated setting appropriate to their needs.The Social Services Director or designee shall be responsible for keeping track of each resident's/patient's PASARR screening status and referring to the appropriate authority.Any Level II resident/patient who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review.Any resident/patient who exhibits a newly evident or possible SMI, ID or RC will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure the physician's orders related to medication hold parameters were followed for 3 of 3 residents reviewed for quality of care. (Resident 13, 2 and 4)Findings include: 1. The clinical record for Resident 13 was reviewed on 7/22/25 at 1:45 p.m. The diagnoses included, but were not limited to, hypertension (high blood pressure), anxiety disorder, and dementia. A physician's order, dated 12/28/22, indicated to administer metoprolol succinate ER (extended release) 25 milligrams (mg), one time a day, with instructions to hold the medication if the systolic blood pressure was below 120. The Medication Administration Record (MAR) for April 2025, June 2025, and July 2025 were reviewed and indicated metoprolol was administered below the ordered hold parameter of 120 on the following days: a. On 4/15/25, with a systolic blood pressure of 93. b. On 4/17/25, with a systolic blood pressure of 117. c. On 4/23/25, with a systolic blood pressure of 110. d. On 6/29/25, with a systolic blood pressure of 114. e. On 7/9/25, with a systolic blood pressure of 114. f. On 7/11/25, with a systolic blood pressure of 110. During an interview, on 7/23/25 at 11:01 a.m., LPN 5 indicated a check mark on the MAR meant the medication was administered. The metoprolol was administered with the systolic blood pressure below the physician's ordered hold parameters. The medication should have been held according to the physician's order. During an interview, on 7/23/25 at 11:04 a.m., the Director of Nursing (DON) indicated the medication had been administered below the physician's ordered hold parameter. 2. The clinical record for Resident 2 was reviewed on 7/22/25 at 10:17 a.m. The diagnoses included, but were not limited to, hypertension, insomnia, and Parkinson's disease. A care plan, dated 1/10/22, indicated Resident 2 had impaired cardiac output related to congestive heart failure, high blood pressure, and high cholesterol. The interventions included, but were not limited to, administering medications as ordered. A physician's order, dated 6/3/23, indicated to give lisinopril 10 mg orally once a day. The instructions indicated the medication should be held if the systolic blood pressure was below 120. The MAR for June 2025 and July 2025 were reviewed and indicated lisinopril was administered below the ordered hold parameter of 120 on the following days: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 6/9/25, with a systolic blood pressure of 109. b. On 6/29/25, with a systolic blood pressure of 115. c. On 7/12/25, with a systolic blood pressure of 107. During an interview, on 7/25/25 at 1:55 p.m., the Assistant Director of Nursing indicated staff should have followed the physician's order and if the systolic blood pressure was outside the parameters, the medication would be held and the physician notified. 3. The clinical record for Resident 4 was reviewed on 7/22/25 at 1:30 PM. The diagnoses included, but were not limited to, dislocation of internal left hip prosthesis, chronic obstructive pulmonary disease, atrial fibrillation, osteoarthritis, and depression. A physician's order, dated 4/1/25 and discontinued 6/23/25, indicated to give metoprolol 25 mg two times a day and to hold for a systolic blood pressure less than 120. A physician's order, dated 6/23/25, indicated to give metoprolol 25 mg two times a day and to hold for a systolic blood pressure less than 120. The MAR for May 2025, June 2025, and July 2025 were reviewed and indicated metoprolol was administered below the ordered hold parameter of 120 on the following days: a. On 5/2/25, in the morning, with a systolic blood pressure of 112.b. On 5/19/25, in the morning, with a systolic blood pressure of 117. c. On 6/16/25, in the evening, with a systolic blood pressure of 119. d. On 7/12/25, in the evening, with a systolic blood pressure of 117. e. On 7/13/25, in the evening, with a systolic blood pressure of 110. f. On 7/14/25, in the morning, with a systolic blood pressure of 114. g. On 7/19/25, in the evening, with a systolic blood pressure of 109.h. On 7/23/25, in the morning, with a systolic blood pressure of 116. i. On 7/24/25, in the morning, with a systolic blood pressure of 112. During an interview, on 7/23/25 at 11:04 a.m., the DON indicated the medication should not have been given with a systolic blood pressure below the physician's ordered hold parameter. A current facility policy, titled Administering Medications, dated April 2019 and provided by the DON on 7/23/25 at 11:10 a.m., indicated .Medications are administered in accordance with prescriber orders 3.1-37(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was assessed and provided pain management prior to the physician's ordered wound treatment for 1 of 1 resident reviewed for pain. (Resident 4)Findings include:During an observation, on 7/21/25 at 12:01 p.m., Resident 4 was sitting in bed with a wound VAC (vacuum assisted closure) (a device used to help close and heal wounds) in place on her left thigh.During an interview, on 7/21/25 at 12:01 p.m., Resident 4 indicated the pain during her wound VAC dressing changes was especially excruciating. She had told the staff every time someone messed with the wound VAC. She indicated the wound VAC was a torture device and the pain from the wound VAC has kept her from getting out of bed and doing things.During an observation, on 7/23/25 at 7:58 a.m., Resident 4 was in bed waiting for the dressing to be changed for her wound VAC. She appeared very anxious with her jaw tight, teeth clenched, and a grimace look on her face. She vocalized ouch multiple times during the treatment, winced and bit her lip. She indicated she did not like having the wound VAC dressing changed because it was extremely painful. She indicated she should at least get a bullet to bite on to help with the pain. She asked multiple times how long she would have the wound VAC. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) indicated the wound VAC had been in place for 10 to 11 weeks, was necessary, and was doing a great job of healing her wound. The resident indicated she wanted her wound to heal but she was tired of the pain.The clinical record for Resident 4 was reviewed on 7/22/25 at 1:30 PM. The diagnoses included, but were not limited to, dislocation of the internal left hip prosthesis, chronic obstructive pulmonary disease, atrial fibrillation, osteoarthritis, and depression.A care plan, initiated 4/2/25, indicated Resident 4 was at risk of pain due to the surgical incision. The goal was the resident would verbalize adequate pain relief with an intervention to administer medication as ordered.A physician's order, dated 4/17/25, indicated to give tramadol (a pain-relieving medication) 50 milligrams (mg) every 8 hours as needed for pain.A physician's order, dated 5/2/25 and discontinued 6/4/25, indicated to place a wound VAC to the left hip with 125 mmHg of continuous suction and to change the dressing every Monday, Wednesday, and Friday.A physician's order, dated 6/25/25, indicated to perform wound care to the left thigh every Monday, Wednesday, Friday, and as needed for a dislodged or vacuum malfunction by cleansing with wound cleanser, patting dry, applying skin prep to peri wound, laying drape, applying black foam to wound base, packing area of tunneling with black foam, applying [NAME] pad, and setting the vacuum to 125mHg continuous suction.A physician's order, dated 7/16/25, indicated staff were to teach the resident how to rate her pain associated with her wound, that her pain was what she defined it to be, the current pain management treatment available to her, and how often it was available.A Medication Administration Record (MAR), dated May 2025, indicated the resident did not receive tramadol for pain prior to her wound VAC dressing changes for 10 of the 13 available times.A MAR, dated June 2025, indicated the resident received tramadol for pain 3 times the entire month on June 12, 28, and 30, and she had received 30 wound dressing changes.A MAR, dated July 2025, indicated that the as needed tramadol for pain was not administered with any of the wound VAC dressing changes before the dressing change observation on July 23, 2025. The medication was not administered before July 23, 2025, during the month of July.A review of the progress notes, dated May through July 2025, lacked documentation there were assessments of pain before wound care was performed or documentation to show Resident 4 was offered pain medication prior to the wound VAC dressing changes.During an interview, on 7/23/25 at 8:08 a.m., the DON indicated he knew the wound VAC dressing change was painful for Resident 4 and she should have been pre-medicated with her pain medicine before every dressing change. He thought she had been receiving pain medication every time and thought she originally was receiving something even stronger than the tramadol 50 mg. He was not sure why her medication was changed or why it had not been given before each of the dressing changes. Resident 4 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been given pain medication to help her tolerate the wound VAC dressing changes before the procedure.During an interview, on 7/28/25 at 9:37 a.m., Resident 4 indicated the pain medicine which had been given before her last couple of dressing changes had helped a little. It had hurt so much for so long, she would get herself all worked up worrying about the pain and had made herself nauseated these past few days. A current facility policy, titled Pain Management, dated 1/2/24 and provided by the Clinical Support Nurse on 7/23/25 at 2:45 p.m., indicated .to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated.Manage or prevent pain, consistent with the.plan of care, current professional standards of practice, and the resident's goals and preferences.A current facility policy, titled Administering Medications, dated April 2019 and provided by the DON on 7/23/25 at 11:10 a.m., indicated .Medications are administered in accordance with prescriber orders 3.1-37(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the Medication and Treatment Administration Records were complete and accurately documented for 3 of 5 residents reviewed for complete and accurate medical records. (Resident 37, 2 and 41)Findings include: 1. The clinical record for Resident 37 was reviewed on 7/22/25 at 10:27 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), hypertension, and bipolar disorder. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), for June 2025, were missing the following documentation for Resident 37: a. The administration of Aricept (a medication used to treat symptoms of Alzheimer's disease and dementia) 5 milligrams (mg) on 6/10/25 at 6:00 p.m. b. The administration of Ativan (an anxiety medication) 0.5 mg on 6/10/25 at 6:00 p.m. c. A completed skin evaluation on 6/11/25 for the evening shift. d. The administration of melatonin (a medication used to mimic the body's natural sleep hormone) 5 mg on 6/10/25 at 6:00 p.m. e. The administration of carvedilol (a medication used to treat cardiovascular conditions) 25 mg on 6/10/25 at 6:00 p.m. f. The administration of gabapentin (a medication used to treat seizures or neuropathic pain) 100 mg on06/10/25 at 6:00 p.m. g. The administration of Namenda (a medication used to treat moderate to severe Alzheimer's disease) 5 mg on 6/10/25 at 6:00 p.m. During an interview, on 7/25/25 at 8:46 a.m., LPN 4 indicated the MAR/TAR should be signed after the medications had been administered or the treatments had been completed. If the documentation had not been completed, the electronic system would show in yellow which meant something was left to be completed or red to indicate the charting was late. During an interview, on 7/25/25 at 8:49 a.m., LPN 4 indicated staff should have signed off the medications or treatments as they were administered. 2. The clinical record for Resident 2 was reviewed on 7/22/25 at 10:17 a.m. The diagnoses included, but were not limited to, hypertension, insomnia, and Parkinson's disease. The MAR and TAR, for June 2025, were missing the following documentation for Resident 2: a. The administration of melatonin (a medication used to mimic the body's natural sleep hormone) 10 mg on 6/10/25 at 6:00 p.m. b. The administration of carboxymethylcellulose sodium solution (a medication used to treat dry, irritated eyes) 0.5% eye drop on 6/10/25 at 6:00 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The administration of galantamine hydrobromide (a medication used to treat symptoms of Alzheimer's disease and dementia) 4 mg on 6/10/25 at 6:00 p.m. d. The administration of Namenda (a medication used to treat moderate to severe Alzheimer's disease) 5 mg on 6/10/25 at 6:00 p.m. e. The administration of lisinopril (a medication used to control blood pressure) 10 mg on 6/19/25 at 6:00 a.m. The MAR and TAR, for July 2025, were missing the following documentation for Resident 2: a. The administration of carboxymethylcellulose sodium solution 0.5% eye drops on 7/18/25 at 6:00 p.m. b. The administration of galantamine hydrobromide 4 mg on 7/18/25 at 6:00 p.m. c. The administration of Namenda 5 mg on 7/18/25 at 6:00 p.m. d. The administration of Sinemet (a medication used to treat symptoms of Parkinson's disease) 25-100 mg on 7/20/25 at 2:00 p.m. 3. The clinical record for Resident 41 was reviewed on 7/22/25 at 10:48 a.m. The diagnoses included, but were not limited to, type 2 diabetes, depression, and congestive heart failure. Physician's orders, dated 1/28/25, indicated to monitor for signs and symptoms of hyperglycemia (high blood sugars) and hypoglycemia (low blood sugars) every shift, to monitor for side effects of diuretic medication use (a medication used to rid excess water and salt in your body) every shift, and to monitor for side effects of anticoagulant medication use (a medication used to prevent blood clots from forming) every shift. The TAR, for May, June and July 2025, were missing the documentation for the monitoring of hyperglycemia and hypoglycemia, anticoagulant and diuretic medication side effects for the following dates for Resident 41: a. On 5/16/25, for the night shift. b. On 5/17/25, for the day and evening shifts. c. On 5/20/25, for the evening shift. d. On 6/7/25, for the night shift. e. On 6/26/25, for the evening shift. f. On 7/1/25, for the night shift. g. On 7/7/25, for the evening shift. h. On 7/8/25, for the night shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. On 7/11/25, for the night shift. j. On 7/12/25, for the day shift. k. On 7/13/25, for the day shift. l. On 7/15/25, for the night shift. m. On 7/16/25, for the night shift. During an interview, on 7/24/25 at 11:37 a.m., LPN 4 indicated medication monitoring should be signed off on every shift. During an interview, on 7/24/25 at 11:43 a.m., the Clinical Support nurse indicated that staff should observe the side effects of the medications as ordered and document 3 times per day. A current facility policy, titled DOCUMENTATION IN THE MEDICAL RECORD, dated as last reviewed on 12/12/23 and received from the Executive Director on 7/24/25 at 1:50 p.m., indicated .Documentation shall be.complete. 3.1-50(a)(1) 3.1-50(a)(2)