STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Terre Haute	3150 N Seventh St Terre Haute, IN 47804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure fingernail care (Residents 4, 5, and 10) and shaving (Resident 52) was provided to residents who required assistance with activities of daily living (ADL) care for 4 of 24 residents reviewed for ADLs. Findings include:1. On 9/7/25 at 11:13 a.m., Resident 4 was observed with long, jagged fingernails on both hands. The resident's fingernails had chipped nail polish and dark debris underneath them. On 9/8/25 at 11:48 a.m., Resident 4 was observed with long, jagged fingernails on both hands. The resident's fingernails had chipped nail polish and dark debris underneath them. Resident 4's record was reviewed on 9/8/25 at 3:16 p.m. Diagnoses on the resident's profile included, but were not limited to, dementia a general term for a group of conditions that cause a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving) and type two diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). A significant change Minimum Data Set (MDS) assessment, dated 8/5/25, indicated the resident had a severe cognitive impairment and required substantial assistance from the staff for personal hygiene. The assessment lacked documentation the resident refused care. A care plan, initiated on 8/23/23, indicated the resident required assistance with ADLs. Interventions included, but were not limited to, nail care on bath days and as needed and report any changes to the nurse. Progress notes, dated August and September 2025, lacked documentation the resident was offered, refused, or provided fingernail care. The electronic point of care (POC) bathing documentation for the last 30 days indicated the resident was scheduled for a shower on Mondays and Thursdays. Shower sheets, dated August and September 2025, indicated the resident received a shower on 8/4/25, 8/7/25, 8/11/25, 8/14/25, 8/18/25, 8/21/25, 8/25/25, 8/28/25, 9/4/25, and 9/8/25. The shower sheets lacked documentation the resident was offered, provided, or refused fingernail care. During an interview, on 9/10/25 at 10:50 a.m., the Director of Nursing (DON) indicated Resident 4 sometimes refused ADL care, but she was not sure if refusals were documented or care planned. During an interview, on 9/10/25 at 11:42 a.m., the Social Services Director (SSD) indicated she was (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Terre Haute		STREET ADDRESS, CITY, STATE, ZIP CODE 3150 N Seventh St Terre Haute, IN 47804	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unable to find documentation Resident 4 refused fingernail care. 2. During an interview, on 9/8/25 at 11:03 a.m., Resident 5's family member indicated when they visited the resident they often found the resident's fingernails not clean. On 9/8/25 at 11:47 a.m., Resident 5 was observed up in the dining room for lunch. The resident's fingernails on both hands had dark debris underneath them. On 9/9/25 at 1:23 p.m., Resident 5 was observed with dark debris underneath her fingernails and chipped nail polish. Resident 5's record was reviewed on 9/9/25 at 2:24 p.m. Diagnoses on the resident's profile included, but were not limited to, cerebral infarction (blood flow to brain interrupted causing brain damage), hemiplegia and hemiparesis (neurological conditions that affect one side of the body) following cerebral infarction, and type two diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). A quarterly Minimum Data Set (MDS) assessment, dated 6/12/25, indicated the resident had a severe cognitive impairment and was dependent on staff assistance for personal hygiene. The assessment lacked documentation the resident refused care. A care plan, initiated on 12/23/23, indicated the resident required assistance with ADLs. Interventions included, but were not limited to, nail care on bath days and as needed and report any changes to the nurse. Progress notes, dated August and September 2025, lacked documentation the resident was offered, provided, or refused fingernail care. The electronic point of care (POC) bathing documentation for the last 30 days indicated the resident was scheduled for a shower on Tuesdays and Fridays. Shower sheets indicated the resident received a shower on 8/1/25, 8/5/25, 8/8/25, 8/12/25, 8/15/25, 8/19/25, 8/22/25, 8/26/25, 8/29/25, 9/2/25, 9/5/25, and 9/9/25. The shower sheets lacked documentation the resident was offered, provided, or refused fingernail care. During an interview, on 9/10/25 at 10:42 a.m., the Director of Nursing (DON) indicated fingernail care should have been provided with showers. If the resident refused fingernail care it probably should have been documented on the shower sheets, but they may just notify the nurse or manager. Nurses provided fingernail care to diabetic residents. During an interview, on 9/10/25 at 10:50 a.m., the DON indicated Resident 5 sometimes refused ADL care, but she was not sure if it was documented or care planned. During an interview, on 9/10/25 at 11:42 a.m., the Social Services Director (SSD) indicated Resident 5 sometimes became physically aggressive with care but was unable to provide documentation the resident refused fingernail care. The SSD indicated care refusal was not normally care planned. 3. On 9/8/25 at 9:51 a.m., during initial observation, observed Resident 10 noted to have long fingernails with debris under nails and heavy beard growth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/25 9:53 a.m., observed Resident 10 in wheelchair noted to have heavy beard growth. The resident indicated he is supposed to be shaved during showers, but the staff had not shaved him for a long time. The resident indicated he would like to be shaved. He indicated he had trimmed his nails, but they needed to be trimmed again. Nails were long with debris under the nails. On 9/10/25 at 9:00 a.m., reviewed the medical record of Resident 10. The resident was admitted to the facility on [DATE]. Admitting diagnosis included but was not limited to type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). A quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident had limited cognition and required assistance of one to provide activities of daily care needs. Review of the Certified Nurse aide (CNA) documentation indicated the resident was administered a shower by the staff at least twice weekly. 4. On 9/8/25 at 10:00 a.m., during initial observation and interview, Resident 52 was noted to have heavy bead growth. The resident indicated he would like to be shaved but the staff had not provided any assistance to shave him. On 9/10/25 at 11:00 a.m. during random observation, Resident 52 had not been shaved. Review of the medical record indicated the resident was admitted to the facility on [DATE]. admission diagnosis included but not limited to congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs) and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A quarterly MDS, dated [DATE], indicated the resident had a mild cognition deficient and required assistance with daily care needs including grooming and dressing. Review of the CNA documentation the record indicated the resident was administered a shower by the staff at least twice weekly. On 9/10/25 at 10:00 a.m., during interview, Licensed Practical Nurse (LPN) 5 indicated the staff shaved residents and trimmed nails on shower days and as needed. She indicated the nurses trimmed nails of diabetic residents. On 9/10/25 at 10:05 a.m., during interview, CNA 11 indicated she shaved the residents on shower days and trimmed their nails if needed. On 9/10/25 at 10:45 a.m., during interview, the Director of Nursing (DON) indicated the residents should be shaved and nail care done on shower days and as needed. On 9/10/25 at 11:49 a.m., the Administrator provided a document, titled, Activities of Daily Living (ADLs), dated 12/12/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Care and Services will be provided for the following activities of daily living.1. Bathing, dressing, grooming and oral care. On 9/10/25 at 10:48 a.m., the DON provided a document, titled, Nail Care, dated 12/12/23, and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.3. Routine cleaning and inspection will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing will be provided on a regular schedule.6. b. Only licensed nurse shall trim or file fingernails of residents with diabetes. 3.1-38(a)(3)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure ulcer (a localized area of tissue damage that develops when prolonged pressure is applied to the skin, usually over a bony prominence) dressing changes were performed with appropriate hand hygiene (Residents 4 and 43), pressure ulcers were staged accurately, and treatments were adjusted when a wound changed (Resident 4) for 2 of 4 residents reviewed for pressure ulcers. Findings include:1. On 9/9/25 at 10:03 a.m., the Wound Nurse was observed completing Resident 4's pressure ulcer dressing change, assisted by Certified Nurse Aides (CNAs) 11 and 13. The Wound Nurse put on a gown and gloves prior to entering Resident 4's room and was not observed to have washed her hands. The Wound Nurse knocked on the resident's door, opened the door, and carried the dressing supplies into the room with her gloved hands. The Wound Nurse placed the supplies directly on the resident's bedside table, with no barrier between the supplies and the table. The Wound Nurse was not observed to clean the resident's bedside table prior to placing the dressing supplies on it. While CNAs 11 and 13 were assisting the resident to stand, the Wound Nurse touched the privacy curtain and the resident's wheelchair with her gloved hands. The Wound Nurse cleansed the wound on the resident's coccyx; while wearing the same gloves she had entered the room with. The Wound Nurse removed the gloves and donned new gloves but did not perform hand hygiene with the glove change. The Wound Nurse applied cream to the wound bed and placed the dressing on the wound. The Wound Nurse removed her gloves, did not perform hand hygiene, and opened the resident's door to retrieve more supplies for the resident's care. Resident 4's record was reviewed on 9/8/25 at 3:16 p.m. Diagnoses on the resident's profile included, but were not limited to, dementia a general term for a group of conditions that cause a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving) and type two diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). A significant change Minimum Data Set (MDS) assessment, dated 8/5/25, indicated the resident had a severe cognitive impairment, required substantial assistance from the staff for activities of daily living (ADLs), and had one stage 3 (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon, or muscle are not exposed, and slough may be present but does not obscure the depth of tissue loss) pressure ulcer that was not present upon admission. A skin evaluation, dated 5/30/25, indicated the resident had a new area of skin impairment on the coccyx (tailbone). The wound was a stage 2 (partial thickness skin loss with a red pink wound bed, without slough) pressure ulcer and measured 1.3 centimeters (cm) in height, 0.7 cm in width, and 0.1 cm in depth. The evaluation indicated a treatment was applied to the area. A physician's order, dated 5/31/25 and discontinued on 7/1/25, indicated cleanse coccyx with wound cleanser, pat dry, apply collagen (promotes healing and new cell growth) to wound bed, and cover with a bordered gauze daily and as needed if soiled or dislodged. A skin condition evaluation, dated 6/10/25, indicated the resident's coccyx wound remained a stage 2 pressure ulcer and measured 1.5 cm in height, 0.8 cm in width, and 0.2 cm in depth. The wound bed was 100 percent granulation tissue (new pink or red tissue). A skin condition evaluation, dated 6/17/25, indicated the resident's coccyx wound remained a stage 2 pressure ulcer and measured 1.3 cm in height, 0.5 cm in width, and 0.2 cm in depth. The wound bed was 100 percent granulation tissue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin condition evaluation, dated 6/24/25, indicated the resident's coccyx wound remained a stage 2 pressure ulcer and measured 1.3 cm in height, 0.4 cm in width, and 0.2 cm in depth. The wound bed was 100 percent granulation tissue. A skin condition evaluation, dated 7/1/25, indicated the resident's coccyx wound remained a stage 2 pressure ulcer and measured 1.5 cm in height, 1 cm in width, and 0.5 cm in depth. The wound bed was 80 percent granulation tissue and 20 percent slough (dead, non-viable tissue only present in stage 3 or greater pressure ulcers). The evaluation lacked documentation the pressure ulcer's stage was upgraded to a stage 3 upon the discovery of slough in the wound bed. A physician's order, dated 7/2/25 and discontinued on 7/22/25, indicated cleanse wound on coccyx with wound cleanser, pat dry, apply hydrogel (treatment to maintain a warm, moist wound bed), and cover with bordered gauze daily and as needed if soiled or dislodged. A skin condition evaluation, dated 7/8/25 indicated the resident's coccyx wound remained a stage 2 pressure ulcer and measured 1.4 cm in height, 0.4 cm in width, and 0.4 cm in depth. The wound bed was 100 percent granulation tissue. A skin condition evaluation, dated 7/15/25, indicated the resident's coccyx wound deteriorated to a stage 3 and measured 2.3 cm in height, 1.4 cm in width, and 0.6 cm in depth. The wound bed was 30 percent granulation tissue and 70 percent slough. The evaluation lacked documentation the physician was notified of the deterioration in the pressure ulcer. Progress notes, dated 7/15/25 to 7/23/25, lacked documentation the physician was notified the resident's pressure ulcer deteriorated. A care plan, last revised on 7/16/25, indicated the resident had a stage three pressure ulcer to the coccyx. Interventions included, but were not limited to, document abnormal findings and notify the physician and notify the physician of worsening or unrelieved symptoms. A skin condition evaluation, dated 7/22/25, indicated the resident's coccyx wound remained a stage 3 and measured 2.1 cm in height, 1.4 cm in width, and 0.5 cm in depth. The wound bed was 100 percent slough. A physician's order, dated 7/23/25, indicated cleanse coccyx with normal saline, apply Santyl (helps remove non-viable tissue) to wound bed, apply calcium alginate (manages wound drainage), and cover with bordered gauze daily and as needed if soiled or dislodged. A skin condition evaluation, dated 9/2/25, indicated the resident's coccyx wound remained a stage 3 and measured 1.9 cm in height, 0.4 cm in width, and 0.4 cm in depth. The wound bed was 50 percent granulation tissue and 50 percent slough. During an interview on 9/10/25 at 1:16 p.m., the Wound Nurse indicated she thought she may have forgotten to bring her hand sanitizer into Resident 4's room for the dressing change so she had not used it when she changed her gloves. She put gloves on before she entered the resident's room so she had to touch her door to open it and enter the room. She was not sure if the wound should have been upgraded to a stage 3 pressure ulcer when slough was noted in the wound bed. The Wound Nurse indicated she thought she had two weeks to notify the physician of changes in the wound, but when asked if there was a change in the wound's condition would the physician be notified right away she indicated, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Well, yeah. During an interview, on 9/10/25 at 1:40 p.m., the Director of Nursing (DON) indicated they were not required to put a barrier down between dressing change supplies and the bedside table if they cleaned the bedside table first. The DON indicated the Wound Nurse told her she cleaned the bedside table, but the DON was not sure. During an interview, on 9/10/25 at 1:50 p.m., the DON indicated if there was slough in the wound bed then it was not a stage two and should have been upgraded to a stage three. If there was a change or deterioration in the wound, such as an increase in the size or stage, the physician should have been notified the same day. During an interview, on 9/10/25 at 1:53 p.m., the Wound Nurse indicated she was unable to provide further documentation the physician was notified when the wound deteriorated on 7/15/25, prior to 7/23/25, when the treatment was changed. On 9/10/25 at 11:44 a.m., the Administrator provided a document titled, Wound Management, dated 1/2/24, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Procedure.5. Treatment decisions will be based on.b. Characteristics of the wound: i. Pressure injury stage.ii. Size.vi. Condition of the tissue in the wound bed.8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing, b. Changes in the characteristics of the wound (see above). On 9/10/25 at 11:44 a.m., the Administrator provided a document titled, Wound Management Policy, dated 5/30/24, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy.It is also the policy of this facility that those residents with impaired skin integrity are recognized by our care team, treated timely, and interventions to heal are not exhausted until the skin is healed.Promotion of treatment and healing of skin integrity impairment: It is the policy of this facility that those residents with impaired skin integrity are recognized by our care team, treated timely, and healing interventions are exhausted until the skin healed.The treatment plan will be professionally interconnected with RCT [Resident Care Team] members to optimize a healing solution. 2. Resident 43's wound dressing change was observed on 9/9/25 at 10:43 a.m. The procedure was performed by the facility wound nurse and assisted by Certified Nursing Assistant (CNA) 11. Prior to entering the resident's room, the wound nurse gathered all supplies from the wound treatment cart. At the same time, she indicated she had already washed her hands prior to gathering the supplies. She was observed with gloves already on her hands. After entering the resident room the wound nurse placed all the supplies for the procedure directly onto the resident's mattress without a barrier. She removed the old dressing from the resident's hip and discarded the dressing into the trash bag which was sitting on the floor next to the bed. She removed her gloves, sanitized her hands with hand sanitizer, donned new gloves and completed procedure. She removed her gloves and threw the gloves into the trash bag next to the bed. The nurse then sanitized her hands with hand sanitizer, left the room, returned to the treatment cart and gathered supplies to perform a treatment to a surgical wound on the resident. She returned to the room, placed the treatment supplies directly onto the resident's bedside table without a barrier. She then donned new gloves and proceeded to begin the treatment. The (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse was not observed to wash her hands between the treatment procedures. Resident 43's record was reviewed on 9/9/25 at 11:23 a.m. The profile indicated the resident's diagnoses included, but were not limited to, syringomyelia (the development of a fluid-filled cyst [a syrinx] within the spinal cord that can compress and damage the cord, causing symptoms like pain, muscle weakness, numbness, and balance issues), syringobulbia (a related condition where this cyst extends into the brainstem, leading to more severe symptoms such as breathing difficulties and swallowing problems), and hemiparesis and hemiplegia following a cerebral infarction (hemiparesis is weakness on one side of the body, while hemiplegia is complete paralysis of one side of the body caused by a stroke). A quarterly Minimum Data Set (MDS) assessment, dated 6/2/25, indicated the resident had severe cognitive deficit, was substantial/maximal to totally dependent with all ADLs (activities of daily living-basic self-care tasks that individuals perform on a regular basis to maintain their daily life) and had a stage 4 pressure wound (a deep, open sore where the damage extends through all skin layers and into the underlying muscle, tendon, cartilage, or bone, often causing extensive tissue destruction). A care plan, dated 8/18/25, indicated the resident had a stage 4 pressure wound to his right hip. Interventions included, but were not limited to, keep the area clean and provide treatment as ordered. A physician's order, dated 9/1/25, indicated to cleanse wound to right hip with wound cleanser, pat dry, apply collagen and calcium alginate, then cover with a bordered dressing daily and as needed for soilage or dislodgement. During an interview, on 9/10/25 at 1:45 p.m., the Director of Nursing (DON) indicated that a barrier should have been used under the wound treatment supplies to keep the supplies clean and handwashing should have been completed between treatments of different wounds. On 9/10/25 at 1:45 p.m., the DON provided an undated document, titled, Validation Checklist Wound Care, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To determine if the individual performing wound care is doing so in accordance with facility policy.Procedure Observed.4. Cleaned bedside table as needed.8. Maintained supplies as sterile/clean as indicated, avoiding contamination.13. Performed hand hygiene. 3.1-40(a)(2)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review and interview, the facility failed to ensure timely documentation and reporting regarding change of resident condition for 1 of 1 resident reviewed for catheter (a thin, flexible catheter used especially to drain urine from the bladder). (Resident 65) Findings include:On 9/07/25 at 12:05 p.m., during interview and observation, Resident 65 had a suprapubic catheter (SPC, a tube that drains urine from the bladder by inserting it through a small incision in the lower abdomen and into the bladder). Resident 65 indicated he did not know why he had a catheter, it was not draining now, and it was leaking. No urine was observed in the tubing or the drainage bag (a collection bag used to drain and store urine).On 9/7/25 at 1:00 p.m., the medical record of Resident 65 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnoses included, but were not limited to, type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), urinary retention (inability to empty the bladder after urinating), and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks).A physician order, dated 1/4/24, indicated supra pubic tube catheter to bedside drainage urinary retention with neurogenic bladder (a condition where the bladder muscles and nerves do not function properly, leading to difficulty or inability to control urination).A physician order, dated 8/28/25, indicated change supra pubic catheter every 4 weeks routinely.A physician order, dated 3/20/24, indicated to provide super pubic catheter care every shift.On 9/8/25 at 1:30 p.m., observed Resident 65 lying in bed. Observed the catheter bag empty of urine and no urine in the drain tube. The resident indicated he had just been changed and was very wet.On 9/8/25 at 1:35 p.m., during interview Registered Nurse RN (8) indicated she was not aware the catheter had not been draining since 9/7/25 and no one had informed her. During review of the medical record with the Unit Manager she indicated the last entry of output was at 5:43 a.m., on 9/8/25 the record indicated urinary output recorded as 450 cc. (cubic centimeters, a unit of measure)On 9/8/25 at 2:00 p.m., during interview the Director of Nursing (DON) indicated the resident had a long standing issue with the catheter and continued to urinate normally. She indicated the nurse had called the physician after being notified of the lack of urine and the catheter was not working. She acknowledged the Certified Nurse Aide (CNA) documentation should only document actual output from catheter.On 9/9/25 at 11:00 a.m., during interview Certified Nurse Aide CNA (7) indicated if a resident had a foley catheter and it was leaking or not draining urine she would report the issue immediately to the nurse as a change in condition.On 9/9/25 at 2:00 p.m., the DON provided a document, titled, Documentation in the medical record, dated 12/12/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.3. Principles of documentation include, but are not limited to.b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and /or responses to care.3.1-41(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Terre Haute	3150 N Seventh St Terre Haute, IN 47804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure respiratory equipment was cleaned and stored appropriately after use for 1 of 1 resident reviewed for respiratory care (Resident 27). Findings include:On 9/07/2025 11:34 a.m., during an initial observation, observed Resident 27 lying in bed. Observed undated nebulizer equipment (a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled), unbagged next to the bedside table. Observed an oxygen storage bag on the bedside table dated 8/25/25.On 9/08/2025 at 10:00 a.m., observed undated nebulizer equipment unbagged on the bedside table of Resident 27.On 9/09/2025 at 9:00 a.m., observed nebulizer mask and tubing unbagged lying in Resident 27 bed. On 9/9/25 at 9:30 a.m., reviewed the medical record of Resident 27. The resident was admitted to the facility on [DATE]. admission diagnoses included, but were not limited to, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and COPD (chronic obstructive pulmonary disease, a group of diseases that cause airflow blockage and breathing-related problems).An admission Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident had limited cognition and required assistance from the staff for daily care needs. A physician order, dated 7/15/25, indicated to administer albuterol sulfate 2.5 mg (milligrams)/3 ml (milliliter) 0.083% nebulization solution inhale 1 vial by mouth every 6 hours as needed for shortness of breath /wheezing.A physician order, dated 9/6/25, indicated to administer ipratropium-albuterol 0.5-2.5 (3) mg/3 ml solution. Inhale 1 vial by mouth via nebulizer every 4 hours for shortness of breath for 7 days.A care plan, dated 7/18/25, indicated the resident was at risk for respiratory distress related to COPD.A care plan, dated 7/14/25, indicated the resident needed assistance with activities of daily living.Review of the Medication Administration Record (MAR) indicated the resident was assessed by the nurse after nebulizer treatment.On 9/9/25 at 10:55 a.m., during interview Licensed Practical Nurse LPN (10) indicated once a resident had completed a nebulizer treatment she would assess the resident and obtain vital signs she would then clean the nebulizer equipment with bleach wipe and leave it to dry for three minutes.On 9/9/25 at 2:00 p.m., the Director of Nursing (DON) provided a document, titled, Oxygen Administration, dated 7/2/25, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.E.5. Keep delivery devices covered in plastic bag when not in use.3.1-47(a)(4)3.1-47(a)(5)3.1-47(a)(6)

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NAME OF PROVIDER OR SUPPLIER: Majestic Care of Terre Haute		STREET ADDRESS, CITY, STATE, ZIP CODE: 3150 N Seventh St, Terre Haute, IN 47804	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were stored and medications were dated when opened for 2 of 2 observations. Findings include:On 9/7/25 at 9:50 a.m., observed unattended medications on the counter at the nurses' station. The prescription label indicated the medications were for Resident 47. The resident was discharged from the facility 9/7/25.On 9/7/25 at 9:55 a.m., during interview Licensed Practical Nurse (LPN) 5 indicated the medications should not be left unattended at the nurses' station. She indicated the resident had just passed away and the medications were removed and left there. She indicated they should have been in the pharmacy.On 9/7/25 at 2:19 p.m., during interview RN 8 the medication cart and computer screen must be locked when she was not at the medication cart.On 9/9/25 at 1:18 p.m., observed 200 hall pharmacy medication room with LPN 5. Observed an opened and undated vial of Aplisol Tuberculin testing solution in the refrigerator. The LPN indicated the vial should have been dated when opened.On 9/7/25 at 11:45 a.m., the Administrator provided a document, titled, Medication Storage, dated 12/12/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.1. General Guidelines.a. All drugs and biologicals will be stored in locked compartments.On 9/9/25 at 2:10 p.m., the Director of Nursing provided a document, titled, Medication Administration, dated 1/27/25, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.3. Multi-dose medication vials/devices a. should be labeled with date opened/accessed.3.1-25(j)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Terre Haute	3150 N Seventh St Terre Haute, IN 47804

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure expired foods were disposed of and failed to ensure food was labeled properly in the walk-in refrigerator for 1 of 2 kitchen observations, and failed to ensure facial hair was covered with hair restraints during 1 of 2 kitchen observations. This deficient practice had the potential to affect 68 out of 69 residents who consumed food out of the kitchen. Findings include:1. During the initial tour of the kitchen, on 9/7/25 at 9:48 a.m., [NAME] 6 identified the dry storage area. The following items were noted on the top shelf of the bread rack:a. A moldy unopened package of hamburger buns. b. An entire loaf of French bread that contained mold. c. A package of sliced raisin bread with a use by date of 8/29/25.d. A 1/2 package of sliced raisin bread with a use by date of 8/29/25.e. Two unopened loaves of sliced raisin bread with a use by date of 8/29/25.During an interview, on 9/7/25 at 10:00 a.m. [NAME] 6 indicated the bread should have been discarded because it was past the use by date and was moldy. In the walk-in refrigerator the following items were observed:a. A plastic container that was full of cooked spiral pasta, the container did not contain a label with a prepared date or use by date. b. A metal container of leftover mashed potatoes, the container did not contain a label with a prepared date or use by date. c. A metal container of leftover chicken noodle soup, the container did not contain a label with a prepared date or use by date. d. A sheet pan full of leftover garlic bread, there was no label with a prepared date or use by date. During an interview, on 9/7/25 at 10:05 a.m. [NAME] 6 indicated leftover food was good for 3 days and then should be discarded. She indicated all food should be labeled with a prepared date and a use by date. 2. During a second kitchen observation on 9/9/25 at 11:02 a.m., [NAME] 9 entered the kitchen and obtained a loaf of bread, block of cheese, and ham slices. The cook washed his hands at the sink and then went to a table in the food prep area and began to make ham and cheese sandwiches for 4 residents. The cook had a full beard and mustache; the beard restraint was not worn properly; the sides of his beard were uncovered along with his mustache. The back of the cook's head was also uncovered; his hair net did not cover the entire back side of his head.During an interview, on 9/9/25 at 11:12 a.m., the Dietary Manager indicated all facial hair should be covered with beard restraints. On 9/7/25 at 11:45 a.m., the Administrator provided a document with a date of 1/2/24, titled, Labeling & Dating Guideline, and indicated it was the current policy being used by the facility. The policy indicated, .All opened and leftover items will be labeled with the date of opening/date stored and a discard/use by date. Storage time frames are as follows: 3 days (72 hours) .Label with the date of storage and the date of discard.When in doubt, throw it out.On 9/9/25 at 11:42 a.m., the Administrator provided a document with a revised date of 2/5/25, titled, Safe Food Handling, and indicated it was the current policy being used by the facility. The policy indicated, .c. shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food.b. Leftover foods will be protected, labeled and dated with the date of original preparation and date of discard.3.1-21(i)(3)

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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 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 record review and interview, the facility failed to ensure that medications were documented as administered, for 1 of 5 residents reviewed for unnecessary medications (Resident 1). Findings include:Resident 1's record was reviewed on 9/8/25 at 2:39 p.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin) and hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone). An admission Minimum Data Set (MDS) assessment, dated 6/11/25, indicated the resident had no cognitive deficit and had no documented behavior of refusals of care. A review of the resident's care plan lacked documentation of the resident refusal of medications, treatments, or care. A physician's order, dated 6/4/25, indicated to administer 8 units of Insulin Glargine medication to treat diabetes 100 units per milliliter (ml) at bedtime for diabetes. The July 2025 Medication Administration Record (MAR) lacked documentation of the 6:00 p.m., dose of the medication being administered on 7/22/25. The record lacked documentation of a resident refusal or unavailability. A physician's order, dated 6/4/25, indicated to administer one 300 milligram (mg) capsule of Gabapentin (medication used to treat seizures and nerve pain) by mouth three times daily for pain. The August 2025 MAR lacked documentation of the morning dose of the medication being administered on 8/15/25. The record lacked documentation of a resident refusal or unavailability. A physician's order, dated 6/5/25, indicated to administer insulin Aspart (medication to treat diabetes mellitus) 100 unit per ml via sliding scale (where the dose of insulin is adjusted based on a person's current blood sugar level) with meals for diabetes. The July 2025 MAR lacked documentation of the 5:00 p.m., dose of the medication being administered on 7/22/25. The record lacked documentation of a resident refusal or unavailability. A physician's order, dated 6/27/25, indicated to administer 50 mcg (micrograms) of levothyroxine sodium (medication to treat hypothyroidism), by mouth two times a day for hypothyroidism. The August 2025 MAR lacked documentation of the morning dose of the medication being administered on 8/15/25. The record lacked documentation of a resident refusal or unavailability. During an interview, on 9/9/25 at 10:00 a.m., the Director of Nursing (DON) indicated medications should be administered at the time they were scheduled. The administration should be documented on the MAR or if not administered a reason why should have been documented. On 9/9/25 at 10:50 a.m., the DON provided a document, dated 1/2/24, titled, Medication Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.14. Administer medications as ordered.17. Sign MAR after administered. 3.1-50(a)(1)