STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155358	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Deming Park	3300 Poplar St Terre Haute, IN 47803

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident's right to be free of sexual abuse was protected for 1 of 3 residents reviewed for abuse (Resident G). The deficient practice was corrected 12/10/25, prior to the start of the survey, and was therefore past noncompliance. Findings include:On 1/15/26 at 11:00 a.m., a review of an Indiana Department of Health reportable incident document dated, 12/9/25 at 4:44 p.m., indicated a hospice staff member who was a Certified Nursing Assistant (CNA) 13, entered the room of Resident H and found resident G sitting on the bed of resident H, with her pants down to her knees. The CNA observed resident H's hands were in resident G's brief. The residents were immediately separated, and Resident H was placed on one to one supervision and an investigation was initiated. 1. On 1/15/26 at 10:30 a.m., the medical record of Resident G was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included 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), muscle weakness and convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders). On 12/9/25 after the incident with the male resident the staff completed a head to toe assessment of resident G. In addition, she was seen by a Nurse Practitioner and a psychological evaluation was completed by psych services. No concerns were identified. A quarterly MDS, dated [DATE], indicated the resident was cognitively impaired. A care plan dated 12/12/25 indicated that the resident exhibited behavioral symptoms of seeking companionship with other residents. Interventions included but were not limited to. One to one initiated on 12/12/25. The record indicated the resident was placed on 15 minute checks from 12/12/25 to 12/28/25. On 1/15/26 at 1:35 a.m., during an interview the Director of Nursing (DON) indicated the facility started 15 minute checks starting on 12/12/25 because they did not think there was a concern between Resident G and other residents. When the facility determined she was seeking the male resident it was determined the resident looked like her husband, and she associated the resident to her husband. She was placed on 15 minute checks, and the care plan was updated. The DON indicated there were no other residents who wander in other residents' rooms. She indicated there had not been any other issues with resident since the initial occurrence. (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

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Deming Park		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Poplar St Terre Haute, IN 47803	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the education and audit tools indicated abuse education of all staff was completed on 12/10/25. The facility completed daily room rounds and weekly interviews from 12/9/25 to current date. 2. Resident H's record was reviewed on 1/16/26 at 11:10 a.m. The profile indicated the resident's diagnoses included but were not limited to, schizophrenia (a severe mental illness causing distorted thinking, perceptions (hallucinations), and behavior, psychotic disorder with hallucinations (involve loss of touch with reality, where individuals perceive things not actually present most commonly hearing voices, but also seeing, feeling, or smelling things that are not there), and adult failure to thrive. Facility census information indicated Resident H admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 11/7/25, indicated the resident was cognitively intact and received anti-psychotic medication. A care plan, dated 12/10/25, indicated the resident had a history of schizophrenia and psychotic disorder with hallucinations.the resident could exhibit behaviors to include inappropriate sexual interactions with others. Interventions included, but were not limited to, 1:1 started on 12/9/25 and ended on 12/12/25, every 15-minute checks, room change 12/12/25, document behaviors per behavior management program, psych services as ordered. A change in condition evaluation form, dated 12/9/25 at 2:46 p.m., indicated Resident H had exhibited sexual behavior changes today. A tele visit note with psychiatry, dated 12/10/25, indicated Resident H had inappropriate behavior with a female resident. Resident H indicated to the nurse practitioner that nothing happened during the incident in question. Resident H indicated a resident entered his room unexpectedly. Treatment would be to continue with one-on-one observation for a minimum of 72 hours. May discontinue one on one after completion of investigation. A social service note, dated 12/10/25 at 8:54 a.m., indicated Resident H was in his room and indicated Resident G had entered his room and sat on his bed. He indicated Resident G was not making any sense when she spoke and was quoted to say, she is not my type, he denied any sexual behaviors or distress. An acute psych visit note, dated 12/11/25 at 11:59 p.m., indicated Resident H denied anything happening with Resident G on 12/9/25. Review of Interdisciplinary Team (IDT) note dated 12/11/25 at 3:55 p.m., Resident H indicated he would like to move rooms so that he would be further away from a female resident who wandered. Resident H would be moved to a new room per his request today. Review of written statement, dated 12/9/25, a hospice staff member who was a Certified Nursing Assistant (CNA) 13 indicated she was at the facility and during her visit she entered Resident H's room to provide care. The curtain was pulled when she entered the room, and she slowly pulled the curtain back. She saw Resident H and Resident G sitting on the side of the bed, both were leaning back. Resident H was fully dressed, but Resident G had her pants down to the knee area, and she was wearing a gray brief, the brief was pulled to the side. CNA 13 noted Resident H's hands were near Resident G's vaginal area. CNA 13 summoned facility staff to assist as she had the residents in sight at the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doorway. Facility staff immediately came to assist CNA 13. Review of written statement, dated 12/9/15, a hospice staff member who was also a CNA 14 indicated she was at the facility to provide resident care. CNA 14 followed CNA 13 into Resident H's room. CNA 14 saw Resident H on the edge of his bed and he was fully dressed. She indicated she saw a female resident sitting on the edge of the bed also and she could visualize the top of her thighs; it appeared her pants were down to the knee area. She left the room and immediately went to get help from the facility staff. Review of written statement, dated 12/9/25 the Director of Nursing (DON) indicated she had spoken with Resident G about the reported event with the presence of a police officer. Resident G indicated she knew who Resident H was and that he resided at the facility but denied she had seen Resident H today. She indicated she was doing great and had no concerns at this time. Review of written statement dated 12/9/25, the DON indicated she had spoken to Resident H about the reported even with the presence of a police officer. Resident H indicated he knew who Resident G was and that she resided at the facility. Resident H indicated that Resident G was in his room earlier that day, he indicated they were talking and standing close to each other. He denied any concerns at this time. Review of written statement, dated 12/9/25, Licensed Practical Nurse (LPN) 6 indicated she did not observe any inappropriate behaviors between Resident G and H on 12/9/25. Review of written statement, dated 12/9/25, Qualified Medication Aide (QMA) 10 indicated at approx. 1:30-2:00 p.m. she saw Resident H in his room with the hospice staff members and Resident G walking around the hallways per usual. During an interview, on 1/15/26 at 1:35 p.m., the Director of Nursing (DON) indicated both residents were separated immediately once the incident was reported by the hospice staff member and Resident H was started on one-on-one observations (and continued to be on every 15-minute checks at this time). The police department was called, and an officer was present at the facility the evening of 12/9/25. The officer interviewed both Resident G and H separately in the DON's office. Neither resident admitted to any concerns. No charges were filed by the police officer. The DON indicated during their investigation they observed Resident G seeking Resident H. Resident G thought Resident H was her husband because they both had a beard and both were smokers. DON denied Resident H ever expressing sexual behaviors before this incident. 32 residents were interviewed by staff on 12/10/25 and denied any resident in the facility had touched them inappropriately. Review of the in-service sign-up sheet, dated 12/10/25, indicated staff were educated on resident rights, abuse, neglect, and sexual expression and intimacy. The sign-up sheet contained 68 staff signatures. On 1/15/26 at 2:30 p.m., the Director of Nursing provided a document, dated 7/1/25, titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, and indicated it was the policy currently being used by the facility. The policy indicated, .b.3. If a resident/patient is accused or suspected. The facility will ensure other residents/patients are protected as determined by the circumstances, which may include but are not limited to, increased supervision of the alleged perpetrator and/or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other residents/patients, room or Care Team Member changes, and immediate transfer or discharge, if indicated. On 1/15/26 at 2:30 p.m., the Director of Nursing provided a document, dated 12/12/23, titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .8. Safe environment. The resident has the right to a safe, clean comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The deficient practice was corrected by 12/10/25 after the facility implemented a systemic plan that included the following actions: Resident H was placed on 1:1 care, interviews were conducted on all resident with a BIMS (Brief Interview for Mental Status) over 8, all residents with BIMS below 8 had head to toe assessment completed, in-servicing education to staff related to abuse, neglect, resident rights, and sexual expression and intimacy, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI). This citation relates to Intake 2689100. 3.1-27(a) 3.1-27(b)