| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155143 | A. Building<br>B. Wing | 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Majestic Care of Terre Haute | 3150 N Seventh St<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect, when the facility failed to ensure a resident was provided adequate monitoring and care for 8 hours for 1 of 3 residents reviewed for neglect (Resident B). Findings include: During a confidential interview, on [DATE] at 6:33 p.m., the interviewee indicated Resident B was not provided monitoring or care from 7:14 p.m. the night of [DATE] until 4:06 a.m. the morning of [DATE]. Resident B was found deceased in her bed in her room by staff at 4:06 a.m. on [DATE]. The family was notified of the death at 4:12 a.m. The family arrived at the facility 21 minutes after they received the call, and Resident B was cold and hard to the touch. The family had installed motion sensor video cameras in the room that verified staff had not checked on the resident for 8 hours. The video was only activated on [DATE] at 7:13 p.m. and then again at [DATE] at 4:06 a.m. Those were the only 2 times staff were noted to be in the resident's room. Review of motion censor camera footage time stamped on [DATE] at 7:13 p.m. indicated staff was in Resident B's room providing care. Resident was resting in bed. Review of motion censor camera footage time stamped on [DATE] at 4:06 a.m. indicated RN 6 entered Resident B's room and found her deceased . On [DATE] at 7:47 p.m., Resident B's record was reviewed, her diagnoses included, but were not limited to, fracture of head and neck of right femur (a break in the bone near the hip joint), acute respiratory failure with hypoxia (a life threatening condition where the lungs cannot adequately oxygenate blood, resulting in low blood oxygen levels), chronic diastolic (congestive) heart failure (a condition where the heart's left ventricle doesn't relax and fill properly during diastole [the filling phase], despite having normal ejection fraction [the amount of blood pumped out with each beat]), and chronic kidney disease stage 3 (moderate kidney damage, where the kidneys are not filtering waste and excess fluid as efficiently as they should). Facility census information indicated Resident B was admitted to the facility on [DATE]. A 5-day Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident B had severe cognitive impairment and was frequently incontinent of urine. A care plan, dated [DATE], indicated the resident needed assistance with activities of daily living due to fracture of the right hip, congestive heart failure, and chronic kidney disease. Interventions included, but were not limited to, assisting with incontinent care, requiring assistance from staff with bed mobility, requiring assistance from staff with personal hygiene, requiring assistance from staff with transfers, and require assistance from staff for toilet use. The record lacked documentation of any nurse's progress notes from 7:14 p.m. on [DATE] till 4:06 a.m., on [DATE]. During an interview, on [DATE] at 7:31 p.m., Certified Nurse's Aide (CNA) 2 indicated that she mostly worked evening shift at the facility and would sometimes work over into night shift as well. She completed bed checks every 2 to 3 hours during her shift. During an interview, on [DATE] at 7:40 p.m., CNA 3 indicated that she mostly worked the evening shift at the facility and would sometimes work over into the night shift as well. She completed 3 bed checks during her 8-hour shift. She indicated most of the staff that she worked with were in the residents' rooms at least every 3 hours. During an interview, on [DATE] at 8:15 p.m., CNA 4 indicated she had gotten to the facility at 8 p.m. on [DATE] and worked through the night shift until morning of [DATE]. CNA 4 indicated she was in Resident B's room at around 9 to 9:30 p.m. on [DATE] and her eyes were closed, but she was breathing (shallow). CNA 4 completed bed checks every 2 hours. CNA 4 was back in Resident B's room around 1:00 a.m. and she wasn't wet (incontinent) and was breathing. The next time she was in the resident's room would have been after 4:00 a.m. and the resident was deceased , and she was cold to touch. During a phone interview, on [DATE] at 8:20 p.m., Registered Nurse (RN) 6 indicated she had obtained Resident B's vitals at the beginning of her shift on [DATE] and entered them into the computer later in the shift on [DATE]. She indicated she no longer waited to enter vitals in the computer anymore and documented them right after they were obtained. RN 6 found Resident B deceased on [DATE] at 4:06 a.m., she indicated the resident was cold to the touch at that time. RN 6 was not made aware of a change in condition for Resident B by any staff members throughout the shift. Review of a staff statement, on [DATE] at 5:50 p.m., indicated CNA 4 was in Resident B's room at 2:00 a.m. on [DATE] and she was still breathing but it was shallow. She advised the nurse at that time of the resident's breathing. Review of a staff statement, on [DATE] with no time stamp, indicated CNA 7 had arrived at the facility at 2:00 a.m. on [DATE] for her shift and she saw CNA 4 leaving Resident B's room at that time. Review of an undated staff statement, indicated RN 6 had arrived to the facility at 6:00 p.m. the night of [DATE] and obtained vital signs from the residents. She was in Resident B's room at 10:00 p.m. with CNA 4 and they were changing her. The next time she was |