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	06/25/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview, the facility failed to ensure a resident's call light was kept within their reach for 1 of 24 residents reviewed for call lights (Resident B). Findings include: On 6/19/25 at 11:24 a.m., Resident B was observed lying in bed. The resident's call light was hanging off the side of the bed, nearly touching the floor. At the same time, the resident indicated she was not sure where the call light was or how she would call for assistance if needed. On 6/23/25 at 9:04 a.m., Resident B was observed lying in bed with the call light within reach. At the same time, the resident indicated she used the call light to call for assistance when needed and grabbed the call light to demonstrate. On 6/25/25 at 9:21 a.m., Resident B was observed lying in bed. The resident's call light was hanging off the side of the bed, approximately halfway to the floor. At the same time, the resident indicated she was not sure where her call light was and felt around with her right hand but was unable to find it. Resident B's record was reviewed on 6/24/25 at 1:37 p.m. Diagnosis on the resident's profile included, but were not limited to, multiple sclerosis (chronic, debilitating disease that affects the central nervous system). A quarterly Minimum Data Set (MDS) assessment, dated 5/20/25, indicated the resident had a moderate cognitive impairment and was dependent for activities of daily living (ADLs). A care plan, initiated on 6/3/25, indicated the resident was at risk for falls. Interventions included, but were not limited to, keep call light within reach. During an interview, on 6/25/25 at 9:23 a.m., Licensed Practical Nurse (LPN) 7 indicated the resident was able to use the call light to call for assistance, and it should have been kept within her reach. During an interview, on 6/25/25 at 9:56 a.m., the Administrator indicated call lights should have been kept within reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 10:48 a.m., the Administrator provided a document titled, Call Lights, dated 1/2/24, and indicated it was the policy currently being used by the facility. The policy indicated, .5. Staff will ensure the call light is within reach of resident and secured, as needed This citation relates to Complaint IN00460327. 3.1-3(v)(1)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During the initial pool interview, on 6/19/25 at 11:12 a.m., Resident E indicated he was supposed to get two showers a week and had not had any this current week and only one the week before. The aides were asking him to sign off the shower sheet even though he was not getting one. Resident E's record was reviewed on 6/23/25 at 10:11 a.m. The profile indicated the resident had been admitted to the facility on [DATE], for diagnoses which included, but were not limited to, hemiplegia and hemiparesis due to cerebral infarction (weakness or paralysis on one side of the body caused by damage to the brain from a stroke). An admission Minimum Data Set (MDS) assessment, dated 6/6/25, indicated the resident had no cognitive deficit and no documentation for refusal of care. A care plan, dated 6/11/25, indicated the resident required assistance with activities of daily living (ADLs-basic tasks that individuals perform to maintain their daily life and care for themselves). Interventions included, but were not limited to, required staff assistance with bathing/showering and personal hygiene. An activity interview for daily and activity preferences document, dated 6/6/25, indicated the resident felt it was very important to choose between a tub bath, shower, bed bath, or sponge bath. A resident preference task document indicated the resident showers preference were on Tuesday and Friday evenings. The point of care (POC) documentation in the medical record (documentation recorded by the Certified Nursing Assistant [CNA] which documented the care that was provided to the resident), indicated the resident was scheduled to have 7 showers administered from 6/1/25 to 6/24/25. The record indicated the resident had received 3 completed showers, had refused 2 showers, and had 1 shower marked NA (not applicable) with no justification for the mark of NA. Review of shower sheets, provided by the Administrator, on 6/24/25 at 2:10 p.m., indicated the following: a. 6/2/25: The document indicated the resident had refused the shower request. The resident had signed the document. b. 6/6/25: The document indicated the resident had refused the shower request. The document lacked a signature from the resident. c. 6/10/25: The document indicated the resident had refused the shower request. The resident had signed the document. d. 6/12/25: The document indicated the resident had refused the shower request. The resident had signed the document. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. 6/13/25: The document indicated the resident had received a shower. The resident had signed the document. f. 6/17/25: The document indicated the resident had refused the shower request. A handwritten note on the document indicated the resident had refused due to the preference of aide. The document indicated the resident had refused to sign. g. 6/19/25: The document indicated the resident had received a shower. The resident had signed the document. h. 6/20/25: The document indicated the resident had refused the shower request. The document lacked a signature from the resident. 3. During observation of the lunch meal service, on 6/19/25 at 12:50 p.m., Resident C was observed with dark debris under her fingernails. Resident C's record was reviewed on 6/23/25 at 11:14 a.m. The record indicated the resident's diagnoses included, but were not limited to, paroxysmal atrial fibrillation (where episodes of irregular heart rhythm start and stop suddenly, either on their own or with treatment, and typically last for less than 7 days) and congestive heart failure (CHF-when the heart muscle doesn't pump blood as efficiently as it should, leading to a buildup of fluid [congestion] in the body). A significant change Minimum Data Set (MDS) assessment, dated 1/17/25, indicated the resident had moderate cognitive deficit and had no documented rejection of care behaviors. A care plan, with a revision dated of 2/5/25, indicated the resident required assistance with activities of daily living (ADLs-basic tasks that individuals perform to maintain their daily life and care for themselves). Interventions included, but were not limited to, required staff assistance with bathing/showering and personal hygiene. A resident preference task document indicated the resident preference was for bed baths on Mondays day shift and a shower on the day shift every Friday. The point of care (POC) documentation in the medical record (documentation recorded by the Certified Nursing Assistant [CNA] which documented the care that was provided to the resident), indicated the resident was scheduled to have 9 bed baths/showers administered from 5/26/25 to 6/23/25. The record indicated the resident had received 5 bed baths and 2 showers during that time period. The record lacked documentation of any refusals of care. Review of shower sheets, provided by the Administrator, on 6/24/25 at 2:10 p.m., indicated the following: a. 6/2/25: The document indicated the resident had received a bed bath, was shaved, and linens were changed. The resident had refused a shower, nail care or having her hair washed. The document indicated the resident was unable to provide a signature. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. 6/6/25: The document indicated the resident had received a bed bath, nail care, and linens were changed. The resident had refused a shower or having her hair washed. The document indicated the resident was unable to provide a signature. c. 6/9/25: The document indicated the resident had received a bed bath. The resident had refused a shower or having her hair washed. The document indicated the resident was unable to provide a signature. d. 6/13/25: The document indicated the resident had received a bed bath. The resident had refused a shower or having her hair washed. The document indicated the resident was unable to provide a signature. e. 6/16/25: The document indicated the resident had received a bed bath, nail care, and linens were changed. The resident had refused a shower or having her hair washed. The document indicated the resident was unable to provide a signature. f. 6/20/25: The document indicated the resident had received a bed bath, nail care, had her hair washed, and linens were changed. The document indicated the resident was unable to provide a signature. The record lacked documentation that the resident had not had her hair washed from 5/26/25 to 6/16/25. The record lacked documentation that the resident had nail care completed from 5/26/25 to 6/13/25. During an interview, on 6/23/25 at 3:18 p.m., the ADM indicated the shower sheets, completed by the CNA's were not a part of the medical record , but were kept separately for internal tracking. During an interview, on 6/24/25 at 9:10 a.m., CNA 5 indicated the aides complete both a shower sheet and would also put the information in the POC system. The dates for the shower sheets and the POC should always match the dates the residents received their showers or bed baths and other care was provided. During an interview, on 6/24/25 at 9:22 a.m., CNA 6 indicated the CNAs would put the shower/bed bath information on both shower sheets and into the POC system. Nail care, washing the resident's hair, and changing bed linen, were all part of the shower/bed bath process. During an interview, on 6/24/25 at 9:46 a.m., Unit Manager 7 indicated the resident were all scheduled for 2 showers a week, but if they requested more, the staff would make sure they received what they wanted. On 6/24/25 at 10:40 a.m., the Director of Nursing (DON) provided a document, dated 1/2/24, titled, Showers, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: 1. Residents will be provided showers as per request or as per facility schedule protocols This citation relates to Complaint IN00460327. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(u)(1) Based on record review and interview, the facility failed to ensure showers were provided to residents based on their preferences for 3 of 24 residents reviewed for choices (Residents B, E, and C). Findings include: 1. Resident B's record was reviewed on 6/24/25 at 1:37 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnosis on the resident's profile included, but were not limited to, multiple sclerosis (chronic, debilitating disease that affects the central nervous system) and nondisplaced transverse fracture (a break in a bone where the two pieces remain aligned and haven't moved out of place) of left patella (knee cap). A care plan, initiated on 5/3/25, indicated the resident required assistance with ADLs. A quarterly Minimum Data Set (MDS) assessment, dated 5/20/25, indicated the resident had a moderate cognitive impairment and was dependent for activities of daily living (ADLs). A physician's order, dated 5/22/25, indicated the resident was to receive a bed bath only, no showers. The current bathing tasks section of the resident's electronic medical record indicated the resident was scheduled for a shower on Tuesdays and Fridays on day shift. The bathing task history, dated June 2025, lacked documentation the resident received any showers. Shower Sheets indicated the resident received a bed bath on 6/3/25, 6/6/25, 6/13/25, 6/17/25, 6/20/25, and a shower on 6/10/25. Progress notes, dated June 2025, lacked documentation the resident refused showers. During an interview, on 6/24/25 at 2:08 p.m., the Director of Nursing (DON) indicated the physician's order for the resident to receive bed baths only was old and should have been removed from the chart. It was in place after the resident was admitted due to her being being post operative after the repair of her patella fracture, but she was cleared by the orthopedic doctor to shower. The DON indicated they asked each resident or their representative how often and what shift the resident wanted to be showered and updated the information in the tasks section of the electronic medical record. The shower schedule in the tasks portion of the chart was the resident's stated preference. During an interview, on 6/25/25 at 9:23 a.m., Licensed Practical Nurse (LPN) 7 indicated the resident was not scheduled for showers and received bed baths only. She did not indicate why the resident's stated preference indicated she wanted showers twice weekly in the tasks section of the chart if she only received bed baths. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 6/25/25 at 9:56 a.m., the Administrator indicated there was no specific facility policy for how resident preferences were documented, but the tasks section of the record should have been consistent with the resident's stated bathing preference.

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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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure nail care was provided for a resident who required assistance with activities of daily living (ADLs) for 1 of 24 residents reviewed for ADLs (Resident B). Findings include: On 6/19/25 at 11:23 a.m., Resident B was observed lying in bed. The resident's fingernails on both hands were untrimmed with dark debris underneath them. At the same time, the resident indicated the staff did not clean her nails very often. On 6/23/25 at 9:04 a.m., Resident B was observed lying in bed. The resident's fingernails on both hands were untrimmed with dark debris underneath them. On 6/25/25 at 9:21 a.m., Resident B was observed lying in bed. The resident's fingernails on both hands were untrimmed with dark debris underneath them. Resident B's record was reviewed on 6/24/25 at 1:37 p.m. Diagnosis on the resident's profile included, but were not limited to, multiple sclerosis (chronic, debilitating disease that affects the central nervous system). A care plan, initiated on 5/3/25, indicated the resident required assistance with ADLs. Interventions included, but were not limited to, nail care on bath day and as necessary. A quarterly Minimum Data Set (MDS) Assessment, dated 5/20/25, indicated the resident had a moderate cognitive impairment and was dependent for ADLs. Shower sheets indicated the resident was bathed on 6/3/25, 6/6/25, 6/10/25, 6/13/25, 6/17/25, and 6/20/25. The shower sheets indicated the resident received nail care on 6/3/25, 6/13/25, and 6/17/25. The shower sheets, dated 6/6/25, 6/10/25, and 6/20/25, lacked documentation nail care was offered or refused. Progress notes, dated June 2025, lacked documentation the resident refused nail care. During an interview, on 6/25/25 at 9:23 a.m., Licensed Practical Nurse (LPN) 7 indicated nail care should have been done with each bath and as needed. On 6/25/25 at 9:48 a.m., the Administrator provided a document titled, Fingernails/Toenails, Care of, revised in February of 2018, and indicated it was the policy currently being used by the facility. The policy indicated, . Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .General Guidelines: 1. Nail care includes daily cleaning and regular trimming .Steps in the Procedure .10. Gently, remove the dirt from around and under each nail with an orange stick . Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given This citation relates to Complaint IN00460327. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(a)(3)(E)