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	11/03/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 Level of Harm - Immediate jeopardy to resident health or safety 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 staff failed to visualize a confused resident during their shift resulting in the resident eloping from the facility for 1 of 3 residents reviewed for neglect (Resident B). The immediate jeopardy began on 10/11/25 when the facility failed to protect the resident's right to be free from neglect when a resident with a traumatic brain injury and at risk of elopement was able to exit the facility sometime after 9:30 p.m., on 10/11/25, or early morning, on 10/12/25, despite wearing a WanderGuard (a type of wander management system used in senior living communities and healthcare facilities to prevent residents at risk of wandering from leaving the premises unsupervised) bracelet. The facility alarm system failed to alert staff of the resident exiting with a WanderGuard. The night shift nurse and night shift Certified Nurse Aide (CNA), on 10/11/25, failed to visualize the resident during their eight hour shift. On 10/12/25, around 7:00 a.m., the day shift staff were unable to locate the resident and started the elopement process. The resident was located approximately 0.6 miles away from the facility. She had a temperature of 95 degrees Fahrenheit and abnormal vitals. The Administrator was notified of the immediate jeopardy on 10/30/25 at 11:39 a.m. The immediate jeopardy was removed on 10/31/25, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:A facility reported incident form, dated 10/12/25, indicated the Administrator was notified Resident B could not be located at 7:11 a.m. The elopement procedure was initiated, and the resident was brought back to the facility. The resident's WanderGuard bracelet was checked and found functional and intact. An incident file included the following documents: -A document titled, Nursing Education/Expectations to Prevent Elopements, indicated, You are expected to lay eyes on all your residents that are under your direct care at minimum of 1-2 times per shift. For safety concerns. The goal is to check on them every 2 hours as you are making rounds to change/medicate them. After you get report for your shift, it is best practice to round your assignment and look in and lay eyes on all the residents and make sure they are accounted for. -A statement from CNA 20 indicated, .When I worked over the weekend I did not go into [Resident B's] room, as she was not on my assignment. I worked 6p [p.m.] to 6a [a.m.] that day and did not see [Resident B] out of her room or see anyone go in there. -A statement from RN 21 indicated, .On 10/11 to 10/12 I worked [unit name]. I didn't see anyone wandering halls. No alarms sounded on the entire shift. I left at 6:30 a.m., arrived at 2200 [10:00 p.m.] on the 11th. -A statement from RN 19 indicated, .I.was [Resident B's] nurse from 10p [10:00 p.m.] to 6a [a.m.].I did not see [Resident B] on my shift, nor did I enter her room at any time during my shift. -A statement from CNA 14 indicated, I.had put [Resident B] to bed on 10/11/25 at 9:30 p.m. The last time I have seen her was 9:40 p.m. when I walked the halls to check on the residents. -A statement from CNA 7 indicated, .I.received a verbal report on [Resident B] when coming on shift for night shift. I did not lay eyes on the resident during report and no call light was used from resident's room during the night. -A statement from CNA 22 indicated I.did not hear any alarms nor did I see [Resident B] the night/morning in questioning [sic]. During an interview, on 10/29/25 at 11:43 a.m., Resident B's family member indicated the facility called him around 8:00 a.m., on 10/12/25, and notified him of the incident. The family member went to the facility, and the resident seemed confused when he arrived. It was cold in the 40's that morning. The resident was found by the school down the road, about a half mile from the facility. The family member was not sure how the resident was able to get out of the facility. The family member was not sure how long the resident was out of the facility. During an interview, on 10/29/25 at 1:24 p.m., Registered Nurse (RN) 4 indicated she was the nurse, on 10/12/25, day shift. She received report from the night shift nurse and was reviewing information for the day. The night shift nurse reported Resident B was fine. RN 4 indicated she went to Resident B's room to check her blood sugar, and her wheelchair was gone and just a sheet was on the bed. She went out into the hallway and asked the aide if she had seen Resident B, but she had not. The staff completed a room to room check of the facility. When they did not find Resident B, RN 4 called the Administrator and sent staff outside to look for the resident. One of the staff members went into a nearby business, and an employee reported seeing someone who fit the resident's description on a bench near the school. The staff found the resident and brought her back to the facility. RN 4 indicated she thought the resident had on long pants and a sweater with tennis shoes, but she was not sure. The resident had her wheelchair full of stuff with her. Residents should have been checked on at least every two hours. RN 4 was not sure how long Resident B

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observation, the facility failed to supervise and prevent a confused resident at risk of elopement from eloping from the facility sometime after 9:30 pm on 10/11/25 into the early morning of 10/12/25 (Resident B). A resident with a traumatic brain injury and at risk of elopement was able to exit the facility sometime after 9:30 p.m. on 10/11/25 or early morning on 10/12/25 despite wearing a WanderGuard bracelet (a type of wander management system used in senior living communities and healthcare and healthcare facilities to prevent residents at risk of wandering from leaving the premises unsupervised). The facility alarm system failed to alert staff of the resident exiting with a WanderGuard. The night shift nurse and night shift CNA on 10/11/25 failed to visualize the resident during their 8-hour shift. On 10/12/25 around 7 a. m. the dayshift staff were unable to locate the resident and started the elopement process. The resident was located approximately 0.6 miles away from the facility. She had a temperature of 95-degree Fahrenheit and abnormal vitals. The Administrator was notified of the immediate jeopardy on 10/30/25 at 11:39 a.m. The immediate jeopardy was removed on 10/31/25, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of a reported facility incident, dated 10/12/25 indicated Resident B was found to be missing when the dayshift nurse could not locate her the morning of 10/12/25 at 7:11 a.m. The Administrator was notified at 7:11 a.m. on 10/12/25 and initiated the elopement protocol. Resident B was located and brought back to the facility. Upon returning to the facility the resident had an intact functioning WanderGuard on. On 10/30/25 at 8:45 a.m., Resident B's medical record was reviewed, her diagnosis included, but were not limited to, traumatic brain injury (an injury to the brain caused by an external force, such as fall, car accident, or assault), Parkinson's disease, (a progressive neurological disorder that affects movement) and type 2 diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin). Census information indicated the resident admitted the facility on 3/15/23. A quarterly Minimum Data Set (MDS) assessment, dated 8/4/25, indicated Resident B had severe cognitive impairment, was occasionally incontinent of urine, and required supervision/touching assistance with toileting. The resident was coded as having one fall since the previous MDS assessment. A care plan, dated 3/28/23 and revised on 4/3/23, indicated Resident B was at risk for elopement due to exit seeking behaviors, impulsiveness, and impaired safety awareness due to diagnosis of traumatic brain injury. Interventions included, but were not limited to, redirect the resident when wandering or was exit seeking by providing a diversional activity, WanderGuard to left ankle, and check placement of WanderGuard every shift and functionality daily. A care plan, dated 3/25/23 with a revised date of 10/12/25, indicated Resident B was at risk for falls or fall related injury due to impaired cognition, impaired mobility, and visual impairment related to diagnosis of traumatic brain injury. Interventions included, but were not limited to, encourage the resident to wear appropriate nonskid footwear, keep call light and frequently used personal items within reach, assist with toileting as needed, and assist with transfers as needed. Review of Morse Fall Scale (a tool used to assess a resident's risk of falling) documentation, dated 9/30/25 at 2:25 p.m., indicated Resident B was a high risk for falls with a score of 65. A score over 45 indicated a resident was a high risk. Review of an elopement risk assessment, dated 9/4/25 at 5:00 p.m., indicated Resident B was at risk for elopement with a score of 3. The resident had a history of or currently exiting seeking and was wandering aimlessly. A progress note, dated 9/4/25 at 5:15 p.m., the note indicated Resident B was wandering aimlessly outside. Staff intervened and walked with her back into the building. The resident indicated she was looking for her keys and the car so that she could leave. The resident was settled into her room and re-oriented to surroundings, but she proceeded to exit seek and indicated she wanted to leave. A WanderGuard was placed on the resident's left lower extremity. A progress note, 10/12/25 at 8:30 a.m., the note indicated Resident B was located outside of the facility and brought back in a facility employee vehicle. The WanderGuard was noted on her left ankle and was functioning properly. The alarm sounded when the resident was brought back into the building through the ambulance bay. The resident was assessed, and the following vitals were obtained: Oral temperature 95.7 degrees Fahrenheit, heart rate 115, respirations 20, blood pressure 188/111, and oxygen saturation 97% on room air. Nonverbal pain scale of 6 out of 10 for back pain. The resident was changed into warm clothing and was given a blanket, hot chocolate and coffee to drink. Repeat vitals were obtained 15 minutes later and the resident had a oral temperature of 98 degrees