

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2026
NAME OF PROVIDER OR SUPPLIER  Majestic Care of Sheridan		STREET ADDRESS, CITY, STATE, ZIP CODE  803 S Hamilton St Sheridan, IN 46069	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified of abnormal blood sugar readings as ordered for 1 of 5 residents reviewed for notification of change. (Resident 65) Findings include: The clinical record for Resident 65 was reviewed on 4/7/26 at 2:00 p.m. The diagnoses included, but were not limited to, type two diabetes mellitus, hypertension, and dementia. A care plan, dated 4/2/25, indicated Resident 65 was at risk for complications and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) with an intervention to obtain blood sugars as ordered and to document and notify the physician of abnormal findings. A physician's order, dated 4/3/25 and discontinued 4/2/26, indicated to obtain an Accu Check (blood sugar reading) four (4) times a day and to notify the provider if the blood sugar reading was less than 90 or greater than 350. The Medication Administration Record (MAR) indicated the following abnormal blood sugar readings were documented with N (no) for physician notification: On 12/26/25, with a blood sugar of 85. On 12/28/25, with a blood sugar of 74. On 12/31/25, with a blood sugar of 368. On 1/18/26, with a blood sugar of 367. On 2/19/26, with a blood sugar of 80. On 3/16/26, with a blood sugar of 83. On 3/18/26, with a blood sugar of 82. On 3/19/26, with a blood sugar of 84. During an interview, on 4/9/26 at 2:56 p.m., the Executive Director (ED) indicated if the physician was in the building at the time the abnormal blood sugar reading was taken, the nurse would have notified the physician and documented the finding in a progress note. During an interview, on 4/9/26 at 3:00 p.m., Licensed Practical Nurse 2 indicated when a N was documented on the MAR, the physician would not have been notified. During an interview, on 4/9/26 at 3:49 p.m., the ED indicated she was unable to find documentation for the physician notification of Resident 65's low blood sugar readings. During an interview, on 4/10/26 at 11:52 a.m., the ED indicated the facility did not have a policy regarding call orders and physician notification. 410 IAC (Indiana Administrative Code) 3.1-5(a)(2) 410 IAC (Indiana Administrative Code) 3.1-5(a)(3)</p>		

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview and record review, the facility failed to ensure incontinence care was provided to a resident with urinary incontinence and more than one incontinence brief was not utilized for 1 of 2 residents reviewed for Activities of Daily Living (ADL) care. (Resident 7) Findings include: 1. During an observation, on 4/6/26 at 12:10 p.m., Resident 7 was lying in his bed, and the side of his pants was visibly wet with urine. His room had a urine smell. During an observation, on 4/6/26 at 2:13 p.m., Resident 7 was still wet and the wet color on his pants was fading. During an interview, on 4/6/26 at 2:16 p.m., Certified Nurse Aide (CNA) 6 indicated he checked on residents every two (2) hours. He had checked Resident 7 last before lunch. During an interview, on 4/6/26 at 2:30 p.m., CNA 6 indicated he had just gone and changed Resident 7 and he was wet. 2. During an observation, on 4/8/26 at 10:14 a.m., Resident 7 was lying in bed with at least two (2) incontinent pads under him. His bed was visibly wet with ring of urinary incontinence around him. During an observation, on 4/8/26 at 12:20 p.m., there was now an even darker ring under the resident of urine along with a lighter ring of urine which was drying. During an observation, on 4/8/26 at 1:44 p.m., Resident 7 was in the same position, and his bed was still wet with urine. During an observation, on 4/8/26 at 1:49 p.m., CNA 4 indicated he last changed Resident 7 at 10:00 a.m. The CNA indicated the resident had not refused any care with him today. The resident slept a lot during the day. The CNA again indicated Resident 7 had not refused any care with him today. During an ADL care observation, on 4/8/26 at 1:50 p.m., CNA 4 was observed to check if Resident 7 needed incontinence care. CNA 4 stopped at the door, saw Resident 7 sleeping, and indicated see, he's sleeping. The CNA was asked if he could check to see if Resident 7 needed care. The CNA asked Resident 7 if he could get him up, and Resident 7 did not respond. Then the CNA asked Resident 7 if he could get him up to be changed, and Resident 7 did not respond. The CNA was then asked if he could educate Resident 7 that he needed care and if CNA 4 could please change him. Resident 7 then got up and allowed the CNA to change him. Resident 7 had two (2) incontinence pads which were soaked with urine. Resident 7's red shirt was soaked at the bottom of his shirt, his incontinent brief was soaked, and the bed sheets were soaked underneath the resident. Resident 7's clothes and bed sheets were changed, and the CNA placed two (2) incontinence briefs on the resident. During an interview, on 4/8/26 at 2:18 p.m., CNA 4 indicated the resident was soaked with urine. He did wet himself heavily and staff were to check him every two (2) hours. He had not refused any care with him today. He typically placed two (2) briefs on Resident 7. The clinical record for Resident 7 was reviewed on 4/8/26 at 10:12 a.m. The diagnoses included, but were not limited to, benign prostatic hyperplasia without lower urinary tract symptoms, vascular dementia, and intellectual disability. The facility point of care response history for bladder elimination, personal hygiene, and behaviors did not indicate the resident had refused care for 4/6/26 or 4/8/26. The clinical record did not indicate any documented refusals, on 4/6/26, in the progress notes. A current care plan, dated 3/9/26, indicated Resident 7 had episodes of incontinence. Staff were to assist with routine toileting and as needed, to check routinely for incontinence and provide incontinence care as needed, to encourage Resident 7 to allow staff to assist him when he was incontinent, and to explain the risks to the resident if he did not allow staff to assist him. The care plan did not indicate the staff were to place two (2) incontinent briefs on Resident 7. During an interview, on 4/9/26 at 3:49 p.m., the Executive Director indicated staff should not place two (2) briefs on a resident unless the resident's care plan indicated. During an interview, on 4/10/26 at 11:28 a.m., CNA 5 indicated if someone refused care, CNAs were to tell the nurse and chart it in the tasks in the record. A current facility policy, titled Resident-Patient Rights, dated effective 4/1/26 and received from the Executive Director on 4/9/26, indicated . Care Team Members will treat each resident/patient with kindness, respect and dignity and provide care that enhances and promotes quality of life and resident/patient preferences and individuality. A current facility policy, titled ACTIVITIES OF DAILY LIVING, dated as last revised on 1/2/24 and received from the Executive Director on 4/9/26 at 3:00 p.m., indicated . The facility will, (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care.Toileting.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(2)(c)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident reviewed infection control. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 4/8/26 at 10:12 a.m. The diagnoses included, but were not limited to, benign prostatic hyperplasia without lower urinary tract symptoms, vascular dementia, and intellectual disability. A physician's order, dated 3/8/26, indicated to utilize Enhanced Barrier Precautions when engaging in high contact resident care activities every shift related to a gastrostomy tube. A current care plan, dated 3/9/26, indicated Resident 7 required enhanced barrier precautions. During an observation, on 4/8/26 at 1:50 p.m., CNA 4 provided incontinence care to Resident 7. The CNA put on gloves to change the resident's incontinence brief but did not put on a gown. The CNA changed Resident 7's urine-soaked brief, wet shirt, wet bed sheets, and wet pants. The wet urine-soaked bed sheet had come into contact with the CNA's uniform. When the CNA was done changing some of the linens, the CNA walked out of the room with a dirty bag of linens and the same pair of gloves and then walked back into the room with the same pair of gloves and continued to provide care. The CNA did not wear a gown during any part of care or change gloves. An enhanced barrier precautions sign located on Resident 7's door indicated ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Cleanse their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the Following High-Contact Resident Care Activities. Dressing. Bathing/showering. Transferring. Changing linens. Providing Hygiene. Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube. During an interview, on 4/8/26 at 2:18 p.m., CNA 4 indicated he did usually put on a gown for care, but he forgot and he should have worn a gown. During an interview, on 4/10/26 at 11:28 a.m., CNA 5 indicated when completing ADL care for a resident, staff should wear a gown and gloves if the resident was in enhanced barrier precautions. A current facility policy, titled Contact Precautions, dated 3/1/25 and received from the Executive Director on 4/10/26 at 11:35 a.m., indicated .Enhanced Barrier Precautions (EBP) is an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident/patient care activities. an order for enhanced barrier precautions will be obtained for residents/patients with any of the following. indwelling medical devices. High-contact resident/patient care activities include, but not limited to. Dressing. Providing hygiene. Changing linens. Changing briefs or assisting with toileting. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(2)</p>		