STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00437150. Complaint IN00437150 - No deficiencies related to the allegations are cited. Survey dates: August 22, 23, 26, 27, 28, and 29, 2024 Facility number: 000067 Provider number: 155143 AIM number: 100267880 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 8 Medicaid: 43 Other: 19 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 10, 2024.	F 0000		
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was completed accurately for 1 of 21	F 0641	MDS for Resident #30 was instantly corrected. Resident was in the process of a Gradual Dose reduction.	08/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wendy Sue McNamara-Baker	HFA	09/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	MDS assessments reviewed (Resident 30). Findings include: Resident 30's record was reviewed on 8/26/24 at 2:43 p.m. The profile indicated the resident's diagnoses included, but were not limited to, psychotic disorder with delusion (a condition that causes people to have strong, fixed beliefs that are not true), schizophrenia unspecified (a condition where a patient's symptoms don't fully meet the diagnostic criteria for schizophrenia or other psychotic disorders), bipolar disorder (a mental illness that causes extreme mood swings, or shifts, that can make it difficult to complete daily tasks), and delusional disorder (mental health condition where a person has a false belief that persists for at least one month, despite evidence to the contrary). A physician's order, dated 2/15/24, indicated to administer one 7.5 milligram (mg) tablet of olanzapine (antipsychotic medication-a class of drugs that treat symptoms of psychosis and other mental health conditions), two times daily for bipolar disorder. A care plan, dated 7/12/23, indicated the resident was at risk for side effects due to receiving psychotropic medications (drugs that affect the mind, emotions, and behavior). Section N0415 of the quarterly MDS, dated 7/26/24, indicated the resident received an antipsychotic medication. Section N0450 of the quarterly MDS, dated 7/26/24, indicated the resident did not receive antipsychotic medications.		MDS were reviewed for accuracy of all resident's receiving a antipsychotic medication. IDT will review Monthly for 3 months any resident receiving an antipsychotic medication for accuracy of the MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 8/26/24 at 2:56 p.m., the MDS Coordinator indicated she had coded the section N0450 of the MDS assessment incorrectly. The section should have been coded to indicate the resident received antipsychotic medication. A copy of Section N of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, dated October 2023, was provided by the MDS Coordinator on 8/26/24 at 2:56 p.m. The manual indicated, "...Section N0450...Coding Instructions...Code 0, no: if antipsychotics were not received...Code 1, yes: if antipsychotics were received on a routine basis only...." 3.1-31(c)(13)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure proper storage of respiratory equipment, and the facility failed to ensure a physician order was obtained for nebulizer treatments for 2 of 4 residents reviewed for respiratory care (Residents 22 and 4). Findings include: 1. On 8/23/24 at 3:03 p.m., Resident 22's unbagged nebulizer mouthpiece and tubing were observed on the resident's side table, there was a clear liquid in the medication chamber (small plastic bowl where medication is placed). The nebulizer machine was observed on the resident's bed. Resident 22's record was reviewed on 8/26/24 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to,	F 0695	It is the policy of the facility to ensure proper storage of respiratory equipment. Residents #22 and #4 were not harmed by the alleged incident. Nebulizer and tubing removed from Resident 22 and 4's rooms. Team (IDT) reviewed Policy and Procedures for nebulizer storage and order administration. IDT reviewed all electronic Medical Records for all residents with order for Nebulizer treatment. IDT ensured all nebulizers and tubing were properly stored per policy. IDT inspected all resident's room	09/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems) and acute respiratory failure with hypoxia (acute or chronic impairment of gas exchange between the lungs and the blood causing hypoxia [inadequate supply of oxygen] with or without hypercapnia [too much carbon dioxide in your blood]). An admission Minimum Data Set (MDS) assessment, dated 6/19/24, indicated the resident was cognitively intact and was not on oxygen therapy at the time. A care plan, dated 6/13/24, indicated the resident was at risk for respiratory distress related to chronic respiratory failure. Interventions included but were not limited to, administer medication as ordered and oxygen as ordered. A physician order, dated 8/16/24 with a discontinue date of 8/21/24, indicated ipratropium-albuterol inhalation solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier); 0.5-2.5mg (milligrams) 3 ml (milliliters). Order was to administer 1 vial inhale orally four times a day for pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid) for 5 days. The record lacked a physician order for a nebulizer treatment beyond 8/21/24. During an interview, on 8/27/24 at 9:38 a.m., Resident 22 indicated she was getting breathing treatments for a few days due to her having pneumonia. She was also using oxygen at night per nasal cannula (a device that delivers extra oxygen through a tube and into your nose).		to ensure only residents with Nebulizer had a Nebulizer machine in their respective room. Inventory was completed on all Nebulizer machines in the facility. Inventory sign out procedure was updated. Nursing Staff was updated regarding new procedures for assigning equipment to a resident. Completed 9/17/24 Nursing staff educated that no nebulizer treatment can be administered without obtaining a physician order and signing the medication off in EMAR system. IDT will review all new orders a minimum of 5 days per week for new nebulizer orders. A member of the IDT team will verify proper storage has been initiated. DNS (Director Nursing Services) has added orders to discontinue nebulizer medication and machine at the completion of the physician order Nursing staff will turn into the DNS or Designee the medication disposition form for review before being scanned into the medical records to ensure compliance. IDT will review the inventory at a minimum weekly. A Member of the IDT team will perform weekly rounds to review and inspect that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 8/28/24 at 9:15 a.m., Qualified Medication Aide (QMA) 8 indicated she had given Resident 22 a nebulizer treatment on the morning of 8/28/24. During an interview, on 8/28/24 at 9:20 a.m., Resident 22 indicated she had received a breathing treatment this morning. During an interview, on 8/28/24 at 9:36 a.m., the Director of Nursing (DON) indicated Resident 22 did not have an order currently for routine or as needed breathing treatments and staff should not administer a medication without a physician order. During an interview, on 8/28/24 at 9:57 a.m., Licensed Practical Nurse (LPN) 4 indicated nebulizer equipment should be placed in a dated bag for storage while not in use. 2. On 8/23/24 at 9:05 a.m., a nebulizer unit (a machine that turns liquid medicine into a mist that can be inhaled through a mouthpiece or mask) was observed sitting on Resident 4's bed side table. At the same time, the resident indicated she had as needed (PRN) breathing treatments. The nebulizer mouthpiece and tubing were unbagged. During a random observation, on 8/26/24 at 12:02 p.m., the resident's nebulizer remained on the bed side table. The nebulizer mouthpiece and tubing were unbagged. During a random observation, on 8/27/24 at 9:12 a.m., the resident's nebulizer remained on the bed side table. The nebulizer mouthpiece and tubing were unbagged. Resident 4's record was reviewed on 8/27/24 at 8:56 a.m. The profile indicated the resident's diagnoses included, but were not limited to,		Nebulizer's for proper storage. A member of the IDT team will review a minimum of 5 residents for weekly 4 weeks, 5 residents every other week for 8 weeks (about 2 months) and finally 5 residents a month for 2 months Attachment A) The logs will be presented to the Executive Director and /or DNS weekly, biweekly and monthly for review. QAPI committee will review the logs in the monthly QAPI meeting to ensure compliance. The QAPI committee will determine if further monitoring will be needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). A quarterly Minimum Data Set (MDS) assessment, dated 7/17/24, indicated the resident had no cognitive deficit, had shortness of breath or trouble breathing when lying flat, and was not on oxygen therapy at the time. A care plan, dated 6/23/23, indicated the resident was at risk for respiratory distress related to COPD and was unable to lie flat due to it causing shortness of breath. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 6/22/23, indicated to administer 2 puffs of albuterol sulfate (a medication that treats and prevents breathing problems caused by lung diseases like asthma and COPD) HFA inhalation aerosol solution (a type of propellant spray) 108 (90 base) micrograms (mcg), every 4 hours as needed for shortness of breath or oxygen saturation (the amount of oxygen circulating in the blood) less than 95%. A historical review of the physician orders lacked documentation of an order for nebulizer treatments. A review of the resident's progress notes from January 2024 through August 2024 lacked documentation that any nebulizer treatments had been administered or that the resident had any order for nebulizer treatments. During an interview, on 8/27/24 at 9:00 a.m., Licensed Practical Nurse (LPN) 3 indicated she had never given the resident a nebulizer treatment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	because she did not believe the resident had an order for a nebulizer. She did have a PRN inhaler ordered, but she rarely requested it. During an interview, on 8/27/24 at 9:18 a.m., Resident 4 indicated she had an inhaler that she would usually use. There had been a day, a couple months ago, that she had a very difficult time breathing and the nurse brought in the nebulizer and gave her a breathing treatment. She was unable to remember what nurse had administered the nebulizer treatment for her. During an interview, on 8/27/24 at 10:17 a.m., the Director of Nursing (DON) indicated she was not aware that the resident had a nebulizer treatment ordered. The nebulizer should not be at the bedside if the resident did not have an order for it and the resident should never be given a nebulizer treatment if there was no order for it. The proper storage of a nebulizer was to ensure the mouthpiece and tubing were stored in a plastic bag when not in use. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided a document, dated 12/12/23, titled. "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Medications are administered...as ordered by the physician...Procedure: ...10. Review MAR to identify medication to be administered. 11. Compare medication source...with MAR to verify resident name, medication...14. Administer medications as ordered...,17. Sign MAR after administration...." On 8/27/24 at 10:55 a.m., the ED provided a document, dated 12/12/23, titled, "Oxygen Administration," and indicated it was the policy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	currently being used by the facility. The policy indicated, "...Procedure: ...5...e. Keep delivery devices covered in plastic bag when not in use...." 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record review, the facility failed to follow physician orders for 1 of 4 residents observed for medication administration (Resident 126). Findings include: During an observation of medication pass, on 8/27/24 at 9:48 a.m., observed Licensed Practical Nurse (LPN 5) confirm Resident 126's order and prepared a Lidocaine patch (patch wore on the skin for pain relief) by initialing and dating it. When the LPN went to apply the new patch, she had to remove an undated Lidocaine skin patch that was located on the resident's back, then she applied the new one. During an interview on 8/27/24 at 9:50 a.m., LPN 5 indicated that the patch she removed from the resident's back before placing the new one was not labeled, did not have a date on it, and should have been removed last night. The patch was only to be left on for 12 hours at a time then left off for 12 hours. She reviewed the medication administration record and determined that the last patch was documented as being applied on 8/26/24 at 8:54 a.m. There was not a place in the MAR to document that patches were removed. On 8/29/24 at 9:02 a.m., a record review for Resident 126 was completed. Her diagnoses	F 0697	It is the facility's policy to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, and comprehensive person-centered care plan and the goals and preferences. The facility reviewed current policy and procedures medication administration Resident #126 was not harmed from the observation. DNS assessed resident Lidocaine patch currently on for 12 hours as ordered on 8/21/24 The nurse's leadership reviewed all residents with orders for transdermal medication and added an entry into the Electronic Medical Record (EMAR) for the nurse to sign off the removal of the transdermal patch. Nursing staff were educated to sign off the removal of the patch and a second nurse to sign a verification of its removal. The nurse will log the removal/destruction on the log. (attachment 9/17/24 The Director of Nursing or will review the removal log and to the for prescribed transdermal weekly for	09/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, but were not limited to, osteoporosis (a disease that causes bones to become fragile and more likely to break), and pain. A physician's order, dated 8/22/24, indicated to apply Lidocaine 5% patch, 1 patch to low back daily, every morning for pain. On for 12 hours then off for 12 hours. A Medicare 5-day Minimum Data Set (MDS) assessment, dated 6/8/24, indicated the resident had a brief interview for mental status (BIMS) score of 12, indicating she had moderate cognitive impairment. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided and identified a document as current facility policy titled, "Medication Administration," dated 1/2/24. The policy indicated, " ...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice ...10. Review MAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, frequency, rout, and time ...14. Administer medication as ordered ...." 3.1-37(a)		4 weeks, biweekly for and monthly for 2 DNS or designee will provide additional education to nursing staff for any identified as not following procedures. DNS or will record on log and turn into Executive Director for review. Logs will be reviewed by the QAPI committee. committee will determine at the end of the 3 months if further monitoring is required.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed, addressed, and dated in a timely manner and failed to ensure documented rationale of pharmacy recommendations for 1 of 5 residents	F 0757	It is the policy of the facility that each resident drug regimen is free of unnecessary drugs. Res #45 was not harmed by the form not being signed. The	09/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed for unnecessary medications (Resident 45). Finding includes: Resident 45's record was reviewed on 8/16/24 at 2:16 p.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems), chronic diastolic congestive heart failure (occurs when left ventricle of the heart becomes still and can't relax properly. This prevents the heart from filling with enough blood between beats, resulting in several symptoms), and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids). An annual Minimum Data Set (MDS) assessment, dated 6/17/24, indicated the resident received medications which included, but were not limited to, insulin injections (medication use to lower blood sugar), anti-depressants (used to treat depressive symptoms), anti-coagulants (used to prevent or reduce blood clots from forming in the bloodstream), diuretics (increase the amount of urine produced in the kidneys) and opioid (prescription pain relief medication). a. A pharmacy recommendation, dated 8/6/23, recommended to reduce midodrine (a medication used to treat low blood pressure that causes severe dizziness or fainting) dose to 2.5 milligrams (mg) three times a day or discontinue if possible. The pharmacy recommendation was not signed, dated, or addressed by the physician.		physician had addressed the recommendation, and orders were received and were documented in the medical record. IDT reviewed monthly pharmacy reports to ensure physicians had addressed all recommendations team educated on timeframe for pharmacy recommendation response time and steps to take if MD has not responded timely by regional nursing consultant. All physicians who receive pharmacy recommendations will be notified of facility requirements for timeliness of response times, and procedure to forward recommendation to facility medical director as needed. The Executive Director will log monthly pharmacy recommendations for the next 5 months and monitor the date sent to MD for signature and date physician returned with signature. If a signature is not received within 14 days (about 2 weeks), the recommendation will be given to the Medical Director for review. The IDT will review the log weekly for 4 weeks, biweekly for and monthly for 2 months to ensure timeliness of physician signature. The log will be reviewed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident's record lacked documentation of the pharmacy recommendation being accepted or denied and the rationale for the decision. A current physician order, dated 4/5/24, indicated to administer midodrine 5 mg, give one tablet by mouth three times a day. b. A pharmacy recommendation, dated 8/6/23, recommended to discontinue the medication Hiprex (used to treat bladder and kidney infections) because the medication was contraindicated with any degree of renal impairment. The pharmacy recommendation was not signed, dated, or addressed by the physician. The resident's record lacked documentation of the pharmacy recommendation being accepted or denied and the rationale for the decision. A current physician order, with an original start date of 2/7/23, indicated to administer Hiprex 1 gram, give one tablet twice a day. c. A pharmacy recommendation, dated 8/6/23, recommended to obtain lab work for the following drugs: atorvastatin (used to treat high cholesterol and triglyceride levels) obtain lipid profile (lab test that measures level of cholesterol and other fats in your blood) every 6 months, insulin obtain Hgb (hemoglobin) a1c (lab test that measures a person's blood sugar level over the past two to three months) every 3 months, furosemide (diuretic medication) obtain BMP (basic metabolic panel [a blood sample test that measures eight different substances in your blood]) every 6 months, cholecalciferol (vitamin D) obtain vitamin D every 6 months, cyanocobalamin (vitamin b12) obtain vitamin b12 yearly, and a CBC (complete blood count [medical test that measures the		QAPI committee monthly, and Medical Director will review and sign monthly to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	number and types of cells in your blood]) The pharmacy recommendation was not signed, dated, or addressed by the physician. Review of a physician progress note, dated 8/21/23, indicated to continue medication as prescribed. The record lacked documentation of which medications the doctor reviewed to continue or a rationale behind continuing the medications. d. A pharmacy recommendation, dated 11/5/23, recommended to reduce the dose or attempt to hold the dose for 2 weeks and if no gastrointestinal symptoms occur, discontinue the medication. The resident was currently on Protonix (used to treat acid reflux and a damaged esophagus) 40 mg twice a day. The physician signed and dated the recommendation on 12/20/23 to reduce the medication to 40 mg daily. A current physician order, dated 12/23/23, indicated to administer Protonix 40 mg, give one tablet by mouth daily. e. A pharmacy recommendation, dated 6/6/24, recommended to attempt a dose reduction of Cymbalta (antidepressant medication). The physician signed and dated the recommendation on 8/9/24 to discontinue the Cymbalta. A social service note, dated 6/11/24 at 9:02 a.m., indicated a behavior meeting was conducted due to gradual dose reduction was due on Resident 45's Cymbalta. Social Service Director (SSD) indicated the facility would request the medication to be discontinued. A physician order, with a discontinued date of 8/13/24, indicated to administer Cymbalta 30 mg,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	give one capsule by mouth daily. f. A second request pharmacy recommendation, dated 6/7/24, recommended labs to be obtained. These were the same labs as advised above. The physician signed and dated the recommendation on 8/9/24. He agreed with recommendation. During an interview, on 8/26/24 at 2:49 p.m., the Director of Nursing (DON) indicated she was not aware of how long it took for some physicians to respond to pharmacy recommendations but should be timely. During an interview, on 8/26/24 at 2:52 p.m., the SSD indicated they had one physician that did not respond to pharmacy recommendations in a timely manner. During an interview, on 8/26/24 at 3:15 p.m., the DON indicated she understood the pharmacy recommendations were not addressed timely, and they may had to involve the Medical Director when physicians were not addressing them in a timely manner. On 8/27/24 at 9:48 a.m., the Administrator provided a document, with a revised date of 2/8/19, titled, "Pharmacy Products and Services," and indicated it was the policy currently being used by the facility. The policy indicated, " ...iii) ...For those issues that require provider intervention, the provider must identify whether they accept or reject part or the whole of the recommendation and must document rationale of why they recommendation is rejected in the resident's medical record ...iv) The responsible provider will respond to the identified irregularities/recommendations within the time frame listed in the facility's policy or at most 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	days ...." 3.1-48(a)(5)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure multi-dose bottle of eye drops and multi-dose vial of tuberculin solution were dated when opened for 1 of 2 medication carts, and 1 of 1 medication rooms observed for medication storage (Resident 126). Findings include: 1. On 8/27/24 at 10:00 a.m., the 200-hall medication cart contained a multi-dose bottle of Latanoprost (treats high pressure in the eye, also known as glaucoma) eye drops for Resident 126. The bottle was opened and not dated. During an interview on 8/27/24 at 10:01 a.m., Licensed Practical Nurse (LPN) 5 indicated that the bottle and the container both should be dated when opened in case they get separated. On 8/29/24 at 9:02 a.m., a record review for Resident 126 was completed. Her diagnoses included, but were not limited to, glaucoma (a chronic eye disease that can cause vision loss and blindness by damaging the optic nerve). A physician's order, dated 8/21/24, indicated to administer Latanoprost solution 0.005%, one drop in both eyes at bedtime for glaucoma. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:53 a.m., she indicated that the Latanoprost eye drops were only good for 6	F 0761	It is the policy of the facility to store and label medication per professional principles. Resident #126 was not harmed from undated eyedrop. The eye drops were delivered to the facility on 8/22/24, Undated eyedrops and Tuberculin solution and new medication ordered from pharmacy. Nurse leadership audited all medication carts on 9/6/24 and verified all medications were properly labeled and dated All licensed nursing staff were regarding policy and procedures for labeling and dating medication. Completed 9/17/24. Medication Storage guide was placed in Nurses Medication Count Book for quick reference. Pharmacists will provide a monthly audit of Medication Cart for properly labeled and dated medications. Director of Nursing or designee will audit medication cart weekly for 4 weeks, biweekly for and monthly	09/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	weeks after opening. 2. On 8/27/24 at 10:06 a.m., the 200-hall medication storage room refrigerator contained a multi-dose vial of Tuberculin Aplisol solution (injectable medication used to test for tuberculosis) that was opened and not dated. On 8/27/24 at 10:07 a.m., LPN 5 indicated that normally the box was dated when opened and the vials had recently been delivered. The package indicated that medication was ordered on 6/5/24, the lot number was 77298. She did not know when the vial could have been opened. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:53 a.m., she indicated that the Tuberculin solution was only good for 30 days after opening. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided and identified a document as current facility policy, titled, "Medication Administration," dated 5/20/2022. The policy indicated, " ...To ensure that the facility, in coordination with the licensed pharmacist, provide for accurate labeling to facilitate safe administration of medications and consideration of precautions in accordance with the currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable ...1. Medication labeling must be typed or printed and clearly indicate ...3. Multi-dose medication vials/devices ...a. should be labeled with date opened/accessed ...ii. Once opened/accessed the vial/device should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for vial/device after opened/accessed		for 2 to ensure compliance. A log will be completed of the audit and any concerns identified. Reeducation will be provided for any identified concerns The Director of Nursing will provide logs to the Executive Director for review. Executive Director will review log to ensure compliance The QAPI committee will review the Pharmacist report monthly and . The QAPI committee will determine if further monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	...." On 8/29/24 at 1:54 p.m., the DON provided and identified a document as current facility policy, titled, "Drug Expiration Dating", dated 2/22/2022. The policy indicated, " ...**ALL medication(s) with shortened expiration dates after opening must be marked with the date opened** ...Aplisol/Tubersol ...Expiration date * ...28 days from date opened** ...." On 8/29/24 at 2:12 p.m., the DON provided and identified a document as the manufacturing package insert from Pfizer for Resident 126's Latanoprost eye drop solution with a revised date of August 2011. The package insert indicated, "...Package insert for the 2.5 mL fill - package of 1 bottle: Xalatan, latanoprost ophthalmic solution 0.005%...Storage ...Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees C (77 degrees F) for 6 weeks ...." 3.1-25(j) 3.1-25(k)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was prepared in a sanitary manner for 1 of 2 kitchen observations. This had the potential to affect 35-38 residents who ate meals from the kitchen. Finding includes: During a continuous kitchen observation of the puree (a smooth, crushed, or blended food that has the consistency of a creamy paste or liquid) food preparation, on 8/27/24 at 10:31 a.m. to 10:50	F 0812	t is the facility's policy to store, prepare, distribute and serve food according to professional food safety standards. No were harmed by the allegation. Cook 11 with return demonstration on hand hygiene practices and kitchen sanitation practices. Dietary Aide 10 on not placing hand in resident food or beverage	09/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m., Cook 11 washed her hands at the sink for less than 20 seconds and began to scoop vegetables into a plastic container to puree them. She proceeded to scoop chicken broth into the container as well. Cook 11 turned on the puree blender and then went over to the steam table to scoop roasted potatoes and chicken broth into another plastic container to puree that was drying on the counter, she grabbed a paper towel to dry it further. She turned on the potatoes and then went back to the vegetables to see if they were completed. The cook had to add thickener to the vegetables because they were too runny. She went back to the potatoes and emptied them into a pan and took the plastic container they were pureed in and began to clean it at the three-compartment sink (manual procedure for cleaning and sanitizing dishes in commercial settings) along with a spatula. She went back to the other counter to check on the vegetables. She grabbed the spatula that was still wet from where she had washed it and used it to place the vegetables in another container and place in oven. Cook 11 took the container that she pureed the vegetables and washed in the 3-compartment sink, she then grabbed a paper towel and dried the container with the paper towel. The cook went back to the steam table and obtained 4 slices of ham and 4 slices of bread with a glove on one hand. The cook finished the ham and placed it into another container and placed in oven. During this entire observation the cook washed her hands at the start of the puree process and no other hand hygiene was observed. During a kitchen observation, on 8/27/24 at 10:55 a.m., Dietary Aide 10 was preparing lemonade into a larch pitcher by using lemonade powder and water. The dietary aid placed his ungloved finger on the inside of the pitcher rim to remove a small		items and what to do if food or beverage item was not standard and needed correction. All dietary staff were Inservice on 9/12/24 regarding safe food handling. All dietary staff had to return hand washing. The cooks were regarding proper food handling Certified Food Manager will review a minimum of 3 food preparations per week for the next 4 weeks, 3 food preparation biweekly for and 3 per month for 2 months Consulting Dietician and Executive Director will review and sign the compliance logs. The QAPI committee will review the logs monthly to ensure compliance. The QAPI committee will determine if further monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	particle and in doing so he touched the inside of the pitcher along with the lemonade as it began to splash out. He then placed a lid on the pitcher along with a sticker that contained a date of when it was prepared. The lemonade was being prepared for the lunch meal service. During an interview, on 8/27/24 at 11:00 a.m., the Dietary Manager indicated staff should not touch the inside of a drink pitcher with ungloved hands and she would be throwing out the lemonade that was contaminated this morning. The Dietary Manager indicated staff should be performing hand hygiene during the puree process when they go from a dirty to clean environment. Cook 11 would have cross contaminated the food going from the clean utensils to dirty utensils to clean again. She further indicated the utensils should be left to air dry and not used if still wet to puree with. On 8/27/24 at 12:28 p.m., the Dietary Manager provided a document, dated 12/12/23, titled, "Dietary Personnel," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The dietary department will employ sufficient and qualified staff to prepare and serve meals and maintain a sanitary environment ...." On 8/27/24 at 12:28 p.m., the Dietary Manager provided a document, dated 12/12/23, titled, "Food Production," and indicated it was the policy currently being used by the facility. The policy indicated, " ...4. Bare hands should never touch raw or ready to eat food directly ...Gloves will be worn for single task preparation then removed and hand hygiene performed ...." On 8/27/24 at 1:55 p.m., the Administrator			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided a document, dated 12/23/23, titled, "Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice ...c. rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers ...." 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observations, interviews, and record review, the facility failed to accurately document medication administration for 1 of 1 resident reviewed for peritoneal dialysis (Resident 43). Findings include: On 8/23/24 at 3:03 p.m., observed a peritoneal dialysis (PD) machine (a treatment for kidney failure that uses the lining of your abdomen, or belly, to filter your blood inside your body), on Resident 43's bedside table. On 8/27/24 at 11:41 a.m., a record review was completed for Resident 43. His diagnoses included, but were not limited to, chronic kidney disease stage 5 (end stage kidney failure), and dependence on renal dialysis (treatment that helps people whose kidneys are no longer able to filter blood properly). A current physician's order, updated 4/25/24, indicated to follow PD orders through the dialysis center. The physician orders were ongoing and could change daily based on clinical assessments	F 0842	It is the policy of the facility to ensure the medical records accurate. Resident #43 was not harmed based on the observation. PD (Peritoneal Dialysis) treatment was being completed by licensed trained staff. Resident #43 is the only PD (Peritoneal Dialysis) is the facility. Facility nursing staff educated on need to log out of computer each time they step away from it to ensure others cannot document under their login and prior to signing out any medication or treatment they should ensure the EMAR system is in under their own personal sign-in information.	09/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reported to the provider. A physician's order, dated 8/16/24, indicated to administer PD treatment: 1.5 (yellow) x 2 (6 Liter) bags (dialysis solutions) via cycler (PD machine) at bedtime. A quarterly Minimum Data Set (MDS) assessment, dated 8/17/24, indicated the resident had a primary medical condition, chronic kidney disease, stage 4, severe. Had an additional diagnosis of dependence on renal (kidney) dialysis, and received dialysis while a resident. On 8/27/24 at 12:16 p.m., a review of the June 2024 Medication Administration Record (MAR) indicated that on 6/9/24, QMA 17 documented that the PD had been administered. On 6/21/24, QMA 18 documented that the PD had been administered. On 8/27/24 2:44 p.m., a review of the July 2024 MAR indicated that on 7/16/24, QMA 16 documented that the PD dialysis had been administered. On 7/18/24, QMA 18 documented that the PD had been administered. On 7/19/24 QMA 16 documented that the PD had been administered. On 7/20/24, QMA 15 documented that the PD had been administered. During an interview on 8/27/24 at 3:11 p.m., QMA 12 indicated that as a QMA he was not trained to administer PD, so the nurse came and set it up for him at night. He was not allowed to get certified. The nurse must call the dialysis center every day to give them an assessment report and receive new orders based on outflow and recorded vitals. Only someone who was certified was allowed to hook up and administer the PD.		Director of Nursing or Designee will review EMAR weekly for 4 weeks, biweekly for and monthly for 2 ensure only licensed staff document PD administration. Reeducation will be provided and documented for any identified concerns. The Executive Director will review the logs. The QAPI committee will review the logs monthly to ensure compliance. The QAPI committee will determine if further monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/27/24 at 3:20 p.m., Licensed Practical Nurse (LPN) 5 indicated that the dialysis company came to train nursing staff on every new resident who received PD, the training included parameters they wanted them to follow. It was mandatory training to be able to give PD to that patient. During an interview on 8/29/24 at 9:32 p.m., QMA 15 indicated that Resident 43 received PD every day. To her knowledge, QMA's were not allowed to be trained to do it. When the nurse came to set up the PD, it was the nurse's responsibility to chart that it was completed. When asked about the MAR dated 7/20/24 where she had charted the PD as being completed, she confirmed that they were her initials documented that day. She was not sure if she just accidently clicked the button. Then indicated she thought that it was possible that she did not sign out of the computer on the medication cart that they parked outside of the resident's room they were working in. She indicated that it was possible that the nurse did not realize that it was logged in under someone else's credentials before going in to sign off that the PD was completed. It had happened before with insulin, and they had to go back and strike it out in an addendum. During an interview on 8/29/24 at 9:46 a.m., when asked about the dates the PD was documented by a QMA, the Director of Nursing (DON) indicated that it was likely that the computer was still logged in under the QMAs when the nurse came and hooked up the PD. QMA 17 and QMA 18 no longer work at the facility. During an interview on 8/29/24 at 11:34 a.m., the Unit Manager indicated that staff should not leave themselves logged into the computers and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unlocked to leave it up to possible give access to information or for someone to potentially get in and document something that you did not do. Staff should never document something that they did not do. Staff should not document under someone else's login, it was their credentials, they should not give anyone their login or password information. Everyone had their own access information. If something like that did happen, they should let someone know as soon as they realize it happened so they could amend it. She was not sure what happened on the days that the QMAs signed off on the PD but they know their scope and what they should and should not sign off on. A QMA cannot do assessments of bruit and thrill, cannot do before and after treatment assessments, and only nurses were trained to administer PD. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided and identified a document as current facility policy, titled, "Medication Administration," dated 5/20/2022. The policy indicated, " ...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection ...." 3.1-50(a)			