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	04/04/2022

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. Survey dates: March 28, 29, 30, 31, and April 1, and 4, 2022 Facility number: 000067 Provider number: 155143 AIM number: 100267880 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 11 Medicaid: 29 Other: 12 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 12, 2022.	F 0000		
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 17 residents reviewed for MDS assessment accuracy (Residents 4 and 43).	F 0641	It is the policy of the facility to complete the MDS accurately. Residents #4 and #43 were not harmed from the inaccurate coding of the MDS. MDS nurse was inserived	04/06/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	04/04/2022

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
	Findings include: 1. On 3/28/22 at 11:09 a.m., Resident 4 was observed lying in bed with both of his feet propped up on a pillow and a boot on his right foot. Resident 4's record was reviewed on 3/31/22 at 9:40 a.m. The facility Matrix indicated Resident 4 had a facility acquired pressure ulcer. A "Condition of Skin, Nails, and Hair" document, dated 3/1/22, indicated Resident 4 had a blister on his right heel with notification to the doctor and wound nurse. A physician's order, dated 3/1/22, indicated apply dry dressing to blister on right heel daily and as needed. A current physician's order, dated 3/25/22, indicated to cleanse heel with wound cleanser, cover with collagen, 4 by (x) 4 and secure with kerlix three times a week and as needed for soilage/dislodgement. A quarterly Minimum Data Set (MDS) assessment, dated 3/11/22, indicated Resident 4 did not have a pressure ulcer. On 4/4/22 at 10:10 a.m., the MDS Coordinator indicated Resident 4 did have a pressure ulcer, but it had been missed on the quarterly MDS assessment, dated 3/11/22. MDS Coordinator indicated she had corrected the quarterly MDS assessment to include the pressure ulcer. A copy of Section M of the Centers for Medicare and Medicaid Services (CMS) Resident		regarding RAI guidelines MDS nurse performed an audit of all MDS completed in the past quarter. MDS verified all residents with impairments, contractures, and wounds were properly marked on the MDS. The MDS/IDT team will complete a monthly audit of all MDS completed for the next 3 months for accuracy. IDT team will review the list of impairments/contractures monthly and compare it to the completed MDS to ensure compliance. IF no further discrepancy is found MDS/IDT will review a minimum of 3 MDS per month for 3 months. All audits will be reviewed by the QAPI committee. If no further discrepancies are found the QAPI committee will recommend ending the audits. IDT will have weekly meetings to review skin integrity issues. The wound nurse will have a report of wounds in the facility with current staging and wound clarification. The MDS nurse will receive a copy of the wound report for reference while completing 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	04/04/2022

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
	Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 4/4/22 at 10:45 a.m. The manual indicated, "...Section M: Skin conditions. Intent: the items in this section document the risk, presence, appearance, and change of pressure ulcers...." 2. During an interview, on 3/29/22 at 9:57 a.m., Resident 43 indicated she had rheumatoid arthritis (RA) and had a significant contracture to her right hand. She was hoping that she could get some therapy exercises to her hand. Resident 43's record was reviewed on 3/31/22 at 2:00 p.m. The profile indicated the resident's diagnoses included but were not limited to, rheumatoid arthritis (an autoimmune and inflammatory disease, in which the immune system attacks healthy cells in the body by mistake, causing inflammation in the affected parts of the body). An admission Minimum Data Set (MDS) assessment, dated 5/1/21, indicated the resident had no cognitive deficit and had no impairment in her upper extremity. During an interview, on 3/31/22 at 2:27 p.m., the MDS Coordinator indicated the resident's upper extremity impairment had been missed when the admission MDS was being completed. The section related to upper extremity impairment had been coded incorrectly. On 3/31/22 at 2:38 p.m., the MDS Coordinator provided documents titled, "CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...G0400: Functional Limitation			

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	04/04/2022

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
	in Range of Motion...Intent: The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living...Definition: Functional Limitation on Range of Motion: Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living)...Steps for Assessment: ...4. Assess the resident's ROM bilaterally at the...wrist, hand, ...Coding Instructions for G0400A, Upper Extremity...Code 0, no impairment: if resident has full functional range of motion on the right and left sides of the upper extremities...Code 1, impairment on one side: if resident has and upper...extremity impairment on one side that interferes with daily functioning...." 3.1-31(a) 3.1-31(c)(3) 3.1-31(c)(4)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, record review, and interview, the facility failed to prevent repeated falls in 1 of 3 residents reviewed for accidents (Resident 11). Findings include: On 3/28/22 at 12:04 p.m., Resident 11 was	F 0689	It is the policy of the facility to ensure residents with the facility will maintain maximum physical function through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. Resident #1 was not injured from	04/15/2022

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	04/04/2022

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
	observed in her wheelchair with a chair alarm in place. There was an anti-roll back device (a mechanism preventing the wheelchair from rolling back when the user sits down or stands up without locking the wheels) on the right side of the chair but was missing on the left. There were anti-tipper devices (a stabilization mechanism to prevent the chair from flipping over) on both sides of the wheelchair, but the right side was missing the small wheels. On 3/30/22 at 11:29 a.m., Resident 11 was observed lying in bed, with her call light out of reach in a bedside chair, and a bed alarm in place. The resident's wheelchair was observed in the hallway with an anti-roll back device on the right side of the chair but missing on the left. There were anti-tipper devices on both sides of the wheelchair, but the right side was missing the small wheels. On 3/31/22 at 11:09 a.m., Resident 11 was observed lying in bed, with her call light out of reach in a bedside chair, and a bed alarm in place. The resident's wheelchair had been repaired, and there was an anti-roll back device on each side of the wheelchair, and both sides of the anti-tippers had the small wheels intact. Resident 11's record was reviewed on 3/30/22 at 1:27 p.m. Diagnoses on the resident's profile included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 1/7/22, indicated the resident had a severe cognitive impairment, required extensive assistance of one staff member for		the results of the allegations of non-compliance. DNS(Director Nursing Services) completed an audit of all residents who experienced a fall in the past 60 days to ensure that proper preventative actions have been put in place to prevent injury related to falls. Audit completed by 4/15/22. Licensed Nursing staff was in serviced on the policy and procedures of fall management. Completed 4/15/22 IDT team was inserved on 4/12/22 regarding the policy of procedures of fall management 1. Preventative measures will be initiated at admission based on Morse Assessment. They will be reviewed quarterly, with significant change and with any fall. 2. Floor nurse will complete documentation in risk management including immediate intervention 3. IDT will review fall next business day. Root cause will be identified, prior interventions reviewed, and new interventions will be initiated. Care plan to be updated. IDT note will be completed in risk management. · Root cause: based on observation/investigation why did the resident fall? The Executive Director and DNS will review and sign all incidents and root cause and care plan . The DNS will present a report to	

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	04/04/2022

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
	transfers, and bed and chair alarms were used daily. A post fall assessment progress note, dated 2/16/22, indicated the resident had a fall witnessed by another resident. The resident fell after trying to stand up from the wheelchair with the brakes unlocked. The resident self-toileted and was wearing slippers. The assessment lacked documentation of an intervention initiated to prevent another fall. A nurse's note, dated 2/16/22, indicated the resident was sent to the emergency room (ER) to rule out internal head injuries. A nurse's note, dated 2/17/22, indicated the resident returned from the hospital with a urinary catheter (a tube inserted through the urethra to drain the bladder) and a diagnosis of urinary retention. A nurse's note, dated 3/4/22, indicated the resident was found sitting on the floor next to her bed with no shoes on. The bed was in the lowest position. The resident frequently takes herself to the bathroom and had a urinary tract infection (UTI) and was assisted back to bed. The root cause of the fall was due to the resident's actions. She had no shoes or nonskid socks on at the time of the fall. The bed alarm was sounding. The intervention was to continue with fall risk protocols. The note lacked documentation of a new intervention to prevent further falls. An interdisciplinary team (IDT) note, dated 3/4/22, indicated post fall follow up. The resident frequently took herself to the bathroom and was found on the floor next to the bed with no shoes or nonskid socks. The probable root cause was		the QAPI committee of all falls and interventions at least quarterly for the next 6 months. The QAPI committee will review compliance and at the end of the 6 months make recommendations for further monitoring.	

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	04/04/2022

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

due to the resident's actions. The note indicated interventions were updated on the care plan but lacked documentation of new interventions put in place to prevent further falls.

A care plan, revised 3/4/22, indicated the resident was a high risk for falls. Interventions, dated 3/4/22, indicated ensure resident was wearing appropriate footwear, nonskid socks when ambulating or mobilizing in wheelchair.

A fall follow up note, dated 3/6/22, indicated the resident was found on the floor at the edge of the bed with her feet under the bed. The resident stated she was going to the bathroom. She did have nonskid socks on, bed in lowest position. The bed alarm was sounding.

An IDT note, dated 3/6/22, indicated post fall follow up note. Resident 11 attempted to get out of bed on her own this morning. She was found sitting on the floor next to her bed with the alarm sounding, and call light was not on. The resident used to self-toilet up until recently. The resident was confused and unaware of her own personal limitations. Staff assisted her to the bathroom the back to bed. Nonskid socks were in place. The root cause analysis is the fall was a result of the resident's actions. Intervention was to continue with at risk care plan. Assist with toileting and observe for resident's needs. The care plan was reviewed and noted. The note lacked documentation a new intervention was put in place to prevent further falls.

A nurse's note, dated 3/11/122, indicated at 11:15 p.m., the resident was heard yelling out. When the nurse entered the resident's room, the resident was found on the floor and stated, "I broke everything." Upon assessment, the resident

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	04/04/2022

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

complained of head pain, pelvic pain, and bilateral hip pain. The right hip was protruded and right leg shorter with inward rotation. The bed alarm was not sounding. When checked, it was plugged in and in place, but not functioning. The resident was sent to the ER for evaluation and treatment.

A nurse's note, dated 3/12/22, indicated the resident returned from the hospital with no report given or notification of return. No fractures were found on x-rays.

An IDT note, dated 3/12/22, indicated post fall follow up note. The resident was found lying on the floor in her room, next to her bed. The bed alarm was in place, but not sounding. She complained of hip and head pain. Upon assessment, the nurse noted the leg looked shorter with inward rotation. The assessment determined a possible hip fracture and head injury. The resident was sent to the ER and returned to the facility at 4:00 a.m. No injury was noted. The resident had always taken herself to the bathroom. She had no safety awareness and had a UTI with diminished strength and increased confusion. Staff frequently toileted her and encouraged her to use the call light for assistance. At the time of the fall, she was in bed with no nonskid socks on and had not turned on the light. The root cause of the fall was several factors, including lack of nonskid socks, bed alarm failure, poor lighting, and resident confusion. Interventions were to put on a toileting schedule and replace bed alarm.

An incident and accident report, dated 3/27/22, indicated the resident got up from bed, walked into the hallway, and fell trying to get into her wheelchair. The bed alarm failed to sound.

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	04/04/2022

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
	An IDT note, dated 3/28/22, indicated a post fall follow up note. The resident was ambulating in the hall and attempted to sit in her wheelchair. The chair was not locked, and the resident fell onto the floor. The resident had no safety awareness and was not aware of need to lock the chair or that she was unable to ambulate on her own. The intervention was to continue with the fall risk care plan. The note lacked documentation of a new intervention put in place to prevent further falls. A care plan, revised on 3/28/22, indicated the resident had an actual fall with no injury on 3/27/22. An intervention, initiated 3/29/22, indicated occupational therapy (OT)/physical therapy (PT) to consult for anti-roll backs to wheelchair on 3/27/22. The care plans lacked documentation of the anti-roll backs prior to this date and lacked documentation of the anti-tippers. During an interview, on 3/31/22 at 11:11 a.m., the Maintenance Director indicated he had repaired the anti-roll backs on the resident's wheelchair that morning. She had one on the wheelchair, but one was missing. He also fixed the anti-tippers because one was missing the wheels. He received a work order from the therapy department requesting the repairs be completed. He was not sure how fall interventions were monitored to make sure they were not in need of repair. He was notified of any repairs needed through the work order system. During an interview, on 3/31/22 at 11:27 a.m., Licensed Practical Nurse (LPN) 12 indicated Certified Nursing Assistants (CNA) were made aware of fall interventions through their assignment sheets and care plans in the electronic system. They checked alarms each shift and documented the check on the 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	04/04/2022

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
	administration record (TAR). Other interventions, such as anti-roll backs and anti-tippers, were not required to be checked regularly. Since they were not checked routinely, she was unsure how they would become aware of problems with them. If she noticed a problem, she would have notified the maintenance director. During an interview, on 3/31/22 at 11:39 a.m., Occupational Therapist (OT) 11 indicated she was familiar with the resident and had evaluated her the prior day. This was the first time she was asked to evaluate the resident. She noticed during the evaluation there was only one anti-roll back on the wheelchair, and one side of the anti-tippers was missing the wheels. The anti-roll backs lock the chair in place if a resident tries to stand up or sit down with the wheels unlocked. With only one side in place, the other side would be able to roll back if the resident sat down. The anti-tippers prevented the wheelchair from tipping over. She was not sure of the reason why the interventions were placed initially or how long they were in place incorrectly. During the clinical meeting, after the last fall, they decided a therapy evaluation should have been completed. The therapy company was new but was in the process of putting in a system for each resident to be screened quarterly. At the time of the screening all fall interventions would have been checked. The resident needed nonskid socks and required assistance with dressing. She was not sure if the resident removed clothes. The call light should have been within the resident's reach, but she was not sure if the resident would use it related to her cognition. The resident was impulsive and had a lack of safety awareness. She used to be able to toilet herself and had recently been placed on a toileting program.			

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	04/04/2022

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 3/31/22 at 11:49 a.m., CNA 10 indicated the resident required nonskid socks and needed assistance to put them on. Once the nonskid socks were in place, she did not remove them. The nurse verbally communicated fall interventions with him and any changes. The resident only had one anti-roll back and one of the anti-tippers was missing the wheels prior to yesterday. He was not sure why it was that way. He was now aware the resident required anti-roll backs and anti-tippers with wheels on each side, so if he noticed a problem with the devices, he would report it. There was no specific routine or requirement for them to be checked.

On 3/31/22 at 12:19 p.m., the resident was lying in bed with her call light out of reach in a bedside chair. At the same time, the Unit Manager served the resident her lunch tray. The Unit Manager indicated the resident was able to get up and take herself to the bathroom and could get the call light then if she wanted to. The resident was not supposed to take herself to the bathroom, but she did regularly. The call light probably should have been with the resident on the bed, but she was unsure if the resident would use it.

During an interview, on 3/31/22 at 12:35 p.m., the Executive Director (ED) indicated the anti-roll backs and anti-tippers were not used as fall interventions for this resident until after the OT evaluation was completed 3/30/22. They were on the wheelchair from the resident who used the wheelchair before Resident 11.

On 3/31/22 at 1:59 p.m., the ED provided a document titled, "Fall Management," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy...to ensure residents residing within 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	04/04/2022

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
	facility will maintain maximum physical functioning. PROCEDURE: ...Post fall: ...4. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent further falls. The fall will be reviewed by the team. IDT note will be written...." 3.1-45(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on observation, interview, and record review, the facility failed to ensure assessments were completed for a dialysis port for 1 of 1 resident reviewed for dialysis (Resident 20). Findings include: On 3/30/22 at 2:05 p.m., Resident 20 was observed with a perma-catheter in his abdomen. Resident 20 indicated he was on peritoneal dialysis each night from 7 p.m. to 7 a.m. and he set up his own dialysis in his room with facility staff assistance, if needed. Resident 20's record was reviewed on 4/4/22 at 8:30 a.m. Diagnoses included, but not limited to, end stage renal disease (kidney failure) and encounter for fitting and adjustment of peritoneal dialysis catheter.	F 0698	The facility will assure that each resident that requires dialysis services, receives such services that are consistent with professional standards. Resident #20 was not harmed. Resident #20 Emar had orders for nurses to assess the peritoneal catheter just lacked the supportative documentation. DNS audited all EMR(electronic medical records) of all residents receiving peritoneal and/or hemo dialysis to ensure orders include documentation of assessment by licensed nursing staff. Completed 4/15/22. All Licensed staff were inserviced on assessment and documentation standards for peritoneal catheter and Assess	04/15/2022

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	04/04/2022

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 quarterly Minimum Data Set (MDS) assessment, dated 1/26/22, indicated the resident was cognitively intact and received dialysis. A care plan, initiated on 11/1/21 and revised on 4/2/22, indicated the resident needed peritoneal dialysis (PD) related to renal failure. Interventions included but were not limited to check and change dressing daily at access and document. A physician's order, dated 2/9/22, indicated PD manual drain every morning before unhooking him from PD. A physician's order, dated 3/14/22, indicated every shift exit site care to PD catheter, everyone must wear a mask including roommate and resident. Close door and follow instructions on PD catheter exit site care handout. Gentamicin 0.1% cream topical small amount to exit site every shift with dressing change. A physician's order, revision dated 3/28/22, indicated resident may administer PD with assistance of nurse to establish home care administration. The clinical record lacked documentation daily PD exit site care and a dressing change were completed. On 4/4/22 at 1:31 p.m., the Director of Nursing (DON) indicated Resident 20 had been on PD dialysis since his admission on 10/19/21. Resident 20's dialysis port should have been assessed and documented daily by a nurse. The facility's computer system had a "glitch" and staff were not able to document the port access assessments. The DON indicated she was not able find a PD assessment order prior to 3/14/22. At that time, the		access sites and ensure dressings are clean, dry and intact if applicable. Assess bruit and thrill (if applicable). Completed 4/15/22 DNS or designee will review EMAR(electronic medical administration records) weekly for the next 30 days to ensure compliance, biweekly for 30 days. Report will be given to the QAPI committee for review and recommendations at the completion of the 60 days.	

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	04/04/2022

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
	DON provided and identified an undated document as a current facility policy, titled "Peritoneal Dialysis Coordination Agreement." The policy indicated, "...ECF (Extended Care Facility) will have sole responsibility for the appropriate care and treatment of all PD Patients while such persons are not in the Company Facility, including, without limitation, assisting with PD fluid exchanges as requested by individual PD patients. ECF's licensed nursing staff will receive and implement all treatment orders from attending physicians and nephrologist in a timely fashion...." 3.1-37(a)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	04/04/2022

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
	standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure leftover and opened foods were disposed of in the required time frame and to store staff food separately from resident food items during 1 of 3 kitchen observations. Findings include: During an initial kitchen tour, on 3/28/22 at 10:02 a.m., a container of honey opened 10/28 was observed in the dry storage area. The walk in refrigerator contained an opened container of leftover pizza sauce dated 3/21/22, an opened container of leftover sweet and sour chicken dated 3/2/221, an opened container of leftover tomato soup dated 3/15/22, an opened container of leftover cream corn dated 3/14/22, an opened bag of green onions dated 1/23/22, a tray of 17 individual dessert bowls containing pudding and apple crisp uncovered and dated 2/23/22, a tray of nine bowls of puree dessert uncovered and dated 3/21/22, a tray of six bean salad bows and four puree desserts uncovered and dated 3/22/22. An upper rack contained three bags with food items inside. At the same time, Cook 7 removed all items past date from the walk in refrigerator and the honey from dry storage for disposal and indicated they should have already been removed. The bags on the upper rack were employee lunches, and she thought they were able to be in the walk in refrigerator for storage. During an interview, on 3/29/22 at 1:28 p.m., the Registered Dietitian (RD) indicated they allowed staff to store their food in the walk in refrigerator. Leftovers were generally removed after 72 hours, but it depended on what the food was. She did not think they had a specific facility policy for	F 0812	It is the policy to the facility to properly label and stored. No residents were harmed. All unlabeled food was discarded immediately All dietary staff were in service by 4/1/22 To ensure compliance the cooks will perform a daily inspection of the walk-in cooler to ensure all food and containers are properly labelled. Items discovered without the proper labeling/date will be immediately discarded. Dietician will perform at least 2 times per week for the next 30 days visual inspection of the walk-in to ensure compliance. Dietician will review the logs kept by the cook daily on days of visual inspection. If no concerns are found in the 30 days the dietician will do once a week inspection for 30 days, then biweekly inspections for 30 more days. At the completion of the 90 days the Dietician will present the logs to the QAPI committee. The QAPI committee will determine further monitoring requirements.	04/05/2022

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	04/04/2022

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
	how long leftovers could be kept, but generally should not be kept longer than a week. She did not think there was a specific facility policy for cleaning out the walk in refrigerator. There was a break room with a refrigerator where staff was able to store food. On 3/29/22 at 2:21 p.m., the RD provided a document titled, "Refrigerators and Freezers," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Statement: This facility will ensure safe refrigerator and freezer...sanitation, and will observe food expiration guidelines. Policy Interpretation and Implementation: ...6. Information regarding acceptable storage periods for perishable foods will be kept in the supervisor's office. A condensed version will be posted by each refrigerator and freezer for reference...8. Supervisors will be responsible for ensuring food items in pantry, refrigerators...are not expired or past perish dates...." On 3/29/22 at 2:58 p.m., the RD provided a document titled, "Food Dating and Labeling Guidelines for Storage," and indicated it was the policy being used by the facility. The policy indicated, "...This facility generally utilizes guidelines that refrigerated leftovers be utilized within 3 days of storage date...." 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in			

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	04/04/2022

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
	accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	04/04/2022

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
	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based upon record review and interview, the facility failed to ensure accurate documentation of a wound to ensure proper staging of a wound for 1 of 2 residents reviewed for pressure ulcers (Resident 17). Findings include: Resident 17's record was reviewed on 3/30/22 at 2:19 p.m. The profile indicated the resident's diagnoses included but were not limited to pressure ulcer of sacral region, stage 4 (a wound characterized by a deep wound that reaches the muscles, ligaments, or even bone). A significant change Minimum Data Set (MDS)	F 0842	It is the policy of the facilty to ensure proper documentation and communication with physicians the condition of the residents. No residents were harmed by the allegation. Resident #17 medical record states a stage 4 from admission. Facility nurses, PCP and Union Hospital wound center records state stage 4. ADNS/Wound nurse rounded with the NP on her initial assessment of Resident #17. Staging of the wound was verbally reported. NP had full access to the medical record to review the history of the	04/15/2022

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	04/04/2022

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
	assessment, dated 7/21/21, indicated the resident was at risk from the development of pressure ulcers and had an unhealed stage 4 pressure ulcer/injury that was present upon admission. A quarterly MDS assessment, dated 1/21/22, indicated the resident was at risk from the development of pressure ulcers and had an unhealed stage 4 pressure ulcer/injury that was present upon admission. A care plan, initiated on 10/21/21, and revised on 1/21/22, indicated the resident had a sacral pressure ulcer. Interventions included, but were not limited to monitor, and document skin status and stage. A document titled, "Diagnosis Report," dated 2/3/22, signed by the physician on 2/24/22, indicated the resident had diagnoses which included, but were not limited to pressure ulcer of sacral region, stage 4. A skin and wound evaluation, dated 2/10/22, completed by the Assistant Director of Nursing Services (ADNS)/wound nurse indicated the wound had been staged as a stage 4. A hospital wound center note, dated 2/14/22, indicated the resident had participated in treatment at the wound center for 50 weeks. The wound documentation described the wound as a stage 4 pressure ulcer. A wound evaluation document, dated 2/24/22, indicated the Nurse Practitioner (NP) had performed an initial assessment of the resident's wound. The NP had identified the wound as a stage 3.		wound including staging. NP can not modify her documentation. Audit was completed by ADNS/wound nurse to verify NP documentation match the facility medical records/assessment. IDT will have weekly meetings to review skin integrity issues. The wound nurse will have a report of wounds in the facility with current staging and wound clarification. The IDT will compare the reports from the NP and compare to the facility assessment. If any discrepancies are noted the ADNS or designee with discuss with the NP and document in the medical record. The weekly report will be reviewed by the QAPI commit at least quarterly for the next 2 quarters. At the completion of the 2 quarters the QAPI committee will make recommendations for further monitoring. The facility medical record and assessment were completed accurately. The Nurse Practioner was given verbal report and wound nurse was present at the time of the assessment. The facility continued to document the wound as a stage 4. The PCP continued to document the wound as a stage 4. NP states it was her assessment as a Stage 3. Supporting documentation attached.	

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	04/04/2022

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 document titled, "Order Summary Report," dated and signed by the physician, on 3/3/22, indicated the resident had diagnoses which included, but were not limited to, pressure ulcer of sacral region, stage 4.

A skin/wound note, documented by the NP on 3/29/22 at 2:16 p.m., indicated a visit for comprehensive skin and wound evaluation. The note indicated the NP had described the wound as a sacral pressure injury, stage 3.

During an interview, on 3/31/22 at 10:11 a.m., the ADNS/wound nurse indicated the NP had assessed the resident's wound for the first time on 2/24/22. She had not communicated any information about the resident's wound to the NP, prior to the initial assessment.

During an interview, on 3/31/22 at 12:29 p.m., the Executive Director (ED) indicated the wound specialists had access to facility resident's electronic medical records and all of the historical record related to all wounds.

During an interview, on 3/31/22 at 2:36 p.m., the NP indicated prior to her initial assessment, she had reviewed a visit note, dated October 2021, when the resident had seen a surgeon to be evaluated for a possible wound flap procedure (a procedure where a section of skin with an intact blood supply and placing it over the injured area). The wound had been described as a stage 3 on the document. She had not been provided any other information from facility staff or reviewed any other wound history prior to completing her initial assessment.

During an interview, on 4/01/22 at 9:07 a.m., the ED indicated the facility would not have any

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	04/04/2022

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
	control over what the wound consultant's determination that the stage of a resident's wound should be. At the same time, the ED provided documentation from the resident's facility physician, dated 2/3/22 and 3/3/22, which indicated the wound was a stage 4. On 3/31/22 at 11:30 a.m., the ED provided an undated document, titled, "Wound Care," and indicated it was the policy currently being used by the facility. The policy indicated, "...Documentation...6. All assessment data...obtained when inspecting the wound...Reporting and Communication...2. Communication to MD/NP will be completed...." 3.1-50(a)(2)			