STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155376	A. BUILDING 00 B. WING	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

(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 30, 31, April 1, 2 and 3, 2025. Facility number: 000336 Provider number: 155376 AIM number: 100290170 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 1 Medicaid: 65 Other: 11 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 7, 2025.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a¿Post Survey Desk Review on 4/21/2025.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the ombudsman was notified of a resident's transfer and discharge to the hospital for 1 of 2 residents reviewed for transfer and discharge. (Resident 55) Findings include: The clinical record for Resident 55 was reviewed on 4/2/25 at 10:16 a.m. The diagnoses included,	F 0623	F 0623 Failed to notify Ombudsmen 1 Ombudsmen notified immediately of discharge to hospital. 2 All other discharges and transfers to the hospital were audited and found to be no others missing.	04/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lauren Kirkwood	HFA, RN	04/18/2025

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	but were not limited to, displaced fracture of the base of the neck of the right femur, muscle weakness, and osteoporosis. The clinical record, dated 8/2/24, indicated Resident 55 fell while attempting to self-transfer. The clinical record, dated 8/3/24, indicated Resident 55 complained of right hip pain. An X-ray was ordered which indicated Resident 55 had a right hip fracture and was transferred to an area hospital by emergency services. Hospital discharge documents indicated Resident 55 was admitted to the hospital on 8/3/24 and discharged back to the facility on 8/8/24. An email from the area ombudsman, dated 4/2/25 at 11:11 a.m., included the discharge information the facility submitted to the ombudsman program for August of 2024. Resident 55 was not included in the documents provided by the ombudsman. During an interview, on 4/2/25 at 10:13 a.m., the Social Service indicated the facility did not have anything further to provide. A document, titled "Family of Social Service Administration," last updated October 2024, indicated "...Dear Nursing Home Administrator: As you know, CMS requires nursing facilities to notify the Long-Term Care (LTC) Ombudsman of the majority of residents' transfers and discharges...When a resident is transferred on an emergency basis to an acute care facility and expected to return, the SLTCO must be notified. Information from facilities regarding emergency transfers should be provided in a monthly list to the SLTCO, which should include residents' names, dates of transfer, facilities to which		3 SSD will be educated on running discharge report accurately and ensuring that all discharges and transfers to the hospital will have the ombudsmen notification at end of each month. This will be provided by the ED/Designee by April 21th, 2025. 4 SSD and ED will complete QAPI tool 1x week x 4 weeks and then monthly x 4 months. Tool will be submitted to QAPI for review, or any further interventions needed. 5 April 21th 2025	

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	residents were transferred, and reasons for the transfers. Please make sure your facility's name is included on the monthly list...." A current facility policy, titled "TRANSFERS & DISCHARGES," dated 1/2/2024 and received from the Clinical Support Nurse on 4/3/25 at 11:42 a.m., indicated "...It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances...Exceptions to the 30-day requirement apply when the transfer or discharge is effected because...An immediate transfer or discharge is required by the resident's urgent medical needs...In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge...Emergency Transfers/Discharges-initiated by the facility for medical reasons to an acute care setting such as a hospital...The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis...." 3.1-12(a)(6)(A)(iv)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure physician's orders were followed, medications were held, and the physician was notified when vital signs were below the ordered parameters for 1 of 5 residents reviewed for quality of care. (Resident 42)	F 0684	F 0684 Quality of Care Failure to follow physician order to notify MD 1. ED/DNS were immediately notified of B/P out of range and failing to notify MD per physician	04/21/2025

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	Findings include: The clinical record for Resident 42 was reviewed on 3/31/25 at 2:00 p.m. The diagnoses included, but were not limited to, hypertension, hypotension, and atrial fibrillation. A physician's order, dated 11/4/24, indicated to administer diltiazem (a medication used to treat high blood pressure) 30 mg (milligram), three (3) times a day with instructions to hold the medication if the systolic blood pressure was below 90 or the heart rate was below 60 and to notify the physician if the systolic blood pressure was below 80. The Medication Administration Record (MAR), dated February 2025, indicated the diltiazem was administered three (3) times with the systolic blood pressure below the physician's ordered hold parameter. The MAR, dated March 2025, indicated the diltiazem was administered three (3) times with the systolic blood pressure below the physician's ordered hold parameter. A physician's order, with a discontinued date of 3/27/25, indicated to administer midodrine (a medication used to treat low blood pressure) 5 mg, three (3) times a day with instructions to hold the medication if the systolic blood pressure was above 120. The MAR, dated February 2025, indicated the midodrine was administered one (1) time with the systolic blood pressure above the physician's ordered hold parameter. The MAR, dated February 2025, indicated		orders. DNS notified MD per order. 2. No s/sx of any harm. No other issues noted. 3. All orders with b/p MD call orders will be checked to ensure correct notification was completed. 4. DNS/Designee will complete QAPI audit tool 5x week x 5 weeks, weekly x 4 weeks, and monthly x 4 months. Tool will be submitted to QAPI for review, or any further interventions needed. 5. April 21st 2025	

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	Resident 42's systolic blood pressure was below 80 on 2/1/25. The nurse documented "n" for physician notification which indicated the physician was not notified. The MAR, dated March 2025, indicated Resident 42's systolic blood pressure was below 80 for two (2) of the three (3) medication administrations on 3/25/25. The nurse's documented "n/a" for physician notification which indicated the physician was not notified. During an interview, on 4/1/25 at 1:19 p.m., Licensed Practical Nurse (LPN) 4 indicated the check marks documented on the MAR meant the medication had been administered and both medications had been administered with systolic blood pressure below and above the physician's ordered hold parameters. During an interview, on 4/1/25 at 2:50 p.m., the Clinical Support Nurse indicated a check mark on the MAR indicated the medications were administered. During an interview, on 4/1/25 at 1:56 p.m., the Administrator indicated the diltiazem and midodrine were both administered with the systolic blood pressure below and above the physician's ordered hold parameters and the physician was not notified of the systolic blood pressures below 80. A current facility policy, titled "MEDICATION ADMINISTRATION," dated 1/2/2024 and received from the Administrator on 4/1/25 at 2:21 p.m., 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			

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	standards of practice...Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters...Report and document any adverse side effects, omittances, or refusals...." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure quarterly smoking assessments were completed for 2 of 2 residents reviewed for accident hazards related to smoking. (Resident 4 and 67) Findings include: During an observation, on 3/30/25 at 10:38 a.m., Resident 4 and Resident 67 were observed to be smoking in the assigned smoking area. 1. The clinical record for Resident 4 was reviewed on 4/1/25 at 9:25 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, malignant neoplasm of the laryngeal cartilage, and encounter for attention to tracheostomy. A care plan, dated 2/14/20, indicated Resident 4 was at risk for injury related to smoking and to complete the smoking assessment quarterly and as needed. A smoking assessment was completed on 11/20/24. There were no current smoking assessments found in the record at the time of the record review.	F 0689	F-689 Smoking Assessment 1 Two smoking assessments failed to be completed. Same late smoking assessments were completed before survey team left the building. 2 Audit performed of all other smoking assessments and no other residents were identified being out of compliance. 3. Activity Director/BCF have been educated on it being their responsibility that smoking assessments be completed according to MDS schedule. Also, explained that floor nurses are not to keep track of this tool being completed timely. 4. ED/DNS/Designee will complete QAPI audit tool 5x week x 5 weeks, weekly x 4 weeks, and monthly x 4 months. Tool will be submitted to QAPI for review or any further interventions. 5. April 21th 2025	04/21/2025

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	A current smoking assessment was requested on 4/1/24 at 1:02 p.m. The facility was unable to provide a current smoking assessment which had been completed after 11/20/24 and prior to 4/1/25. 2. The clinical record for Resident 67 was reviewed on 4/1/25 at 11:01 a.m. The diagnoses included, but were not limited to, lack of coordination, tobacco use, and alcohol dependence with alcohol induced persisting dementia. A care plan, dated 4/22/24, indicated Resident 67 was at risk for injury related to smoking and to complete the smoking assessment quarterly and as needed. A smoking assessment was completed on 11/1/24. There were no current smoking assessments found in the record at the time of the record review. A current smoking assessment was requested on 4/1/25 at 1:02 p.m. The facility was unable to provide a current smoking assessment which had been completed after 11/1/24 and prior to 4/1/25. During an interview, on 4/2/25 at 10:17 a.m., the Executive Director indicated smoking assessments were to be completed quarterly. A current facility policy, titled "Smoking," dated as effective 2/19/25 and received from LPN 5 on 4/2/25 at 10:37 a.m., indicated "...Each resident/patient who smokes must have a smoking assessment completed...quarterly...." 3.1-45(a)(1)			