| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155358 | A. BUILDING 00<br>B. WING | 04/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| MAJESTIC CARE OF DEMING PARK | 3300 POPLAR ST<br>TERRE HAUTE, IN 47803 |

| (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 |
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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: March 31, April 3, 4, 5, and 6, 2023<br><br>Facility number: 000249<br>Provider number: 155358<br>AIM number: 100267640<br><br>Census Bed Type:<br>SNF/NF: 47<br>Total: 47<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 26<br>Other: 14<br>Total: 47<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on April 13, 2023. | F 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 5-1-2023 to the annual licensure survey completed on 4-6-2022. We respectfully request a paper review and will provide any additional information requested. | |
| F 0584<br>SS=E<br>Bldg. 00 | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike Environment<br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Pamela Clevenger | HFA, Executive Director | 04/28/2023 |

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.

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| | to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>Based on interview and record review, the facility failed to ensure comfortable hot water temperatures for 18 of 45 rooms reviewed for water temperatures.<br><br>Findings include: | F 0584 | F584<br>Safe/Clean/Comfortable/Homelike Environment<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Mixing valve was replaced on 4-6-23. 2” water | 05/01/2023 |

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| | During an initial pool family interview, on 3/31/23 at 2:59 p.m., Resident 7's family member indicated the water in the resident's shower took a long time to get warm and never got hot. She had reported it to the administration and was told that they had a valve issue. At the same time, the family member asked the resident how long it took for the water, in her shower, to get hot. The resident indicated it took up to 20 minutes, just to be warm enough to get under it,<br><br>On 3/31/23 at 3:01 p.m., the water in the shower was manually inspected. The water was run for more than 2 minutes and never felt warm to the touch.<br><br>During an interview, on 3/31/23 at 3:19 p.m., the Administrator (ADM) indicated they had been working on a mixing valve on one of the two facility water heaters. She was unsure which water heater was responsible for heating which area of the facility and of what the water temperatures had been running throughout the facility. She had called the Maintenance Director and requested he perform a full temperature check for each room of the facility.<br><br>On 4/3/23 at 9:30 a.m., the Maintenance Director provided documents, dated 4/1/23 and 4/2/23, titled, "Hot Water Temperature Log," and indicated the temperatures on the log were the result of facility-wide room water temperature checks performed on the dates listed on the documents. At the same time, the Maintenance Director indicated he believed the proper temperature range for comfortable and safe water, was 100 degrees Fahrenheit (F) to 120 degrees F.<br><br>Review of the hot water temperature log, dated | | line repaired from the water heater and the ball valve was adjusted. The ball valve was found to be opened too far during last repair by Gibson CO on 04.06.23 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in facility have the potential to be affected by the alleged deficient practice. No negative outcomes in any room affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director educated on appropriate and safe water temps for facility on 4-25-2023. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Water temperature checks daily x 4 weeks, daily x 2 weeks, then weekly by maintenance director/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting. | |

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| | 4/1/23, indicated the following:<br><br>a. Room 116 water temperature measured 85 degrees F.<br><br>Review of the hot water temperature log, dated 4/2/23, indicated the following:<br><br>a. Room 107 water temperature measured 93 degrees F.<br><br>b. Room 110 water temperature measured 93 degrees F.<br><br>c. Room 116 water temperature measured 99 degrees F.<br><br>d. Room 206 water temperature measured 99 degrees F.<br><br>e. Room 216 water temperature measured 97 degrees F.<br><br>f. Room 218 water temperature measured 95 degrees F.<br><br>g. Room 223 water temperature measured 97 degrees F.<br><br>h. Room 224 water temperature measured 94 degrees F.<br><br>i. Room 227 water temperature measured 99 degrees F.<br><br>j. Room 229 water temperature measured 95 degrees F.<br><br>k. Room 231 water temperature measured 92 degrees F. | | | |

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| | l. Room 233 water temperature measured 96 degrees F.<br><br>m. The Central Bath room water temperature measured 96 degrees F.<br><br>During an interview, on 4/4/23 at 12:25 p.m., the Regional Director of Facilities indicated he had been notified of water feeling cold when turned all the way over to hot. The facility had been adjusting the mixing valve and the water continued to read cold. The hot water temperatures in bathrooms, located in the front of building were reading at 68 degrees F.<br><br>During an interview, on 4/5/23 at 2:40 p.m., Certified Nursing Assistant (CNA) 14 indicated that a lot of the time it had been taking time for the water in the resident's room to get warm. This was especially in the rooms towards the front of the building.<br><br>During an interview, on 4/5/23 at 2:45 p.m., Licensed Practical Nurse (LPN) 15 indicated there had been an issue with the water in some of the resident's rooms getting warm.<br><br>On 4/4/23 at 12:53 p.m., the Maintenance Director provided a document, dated 2/1/22, titled, "Safe Water Temperatures," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of this facility to maintain appropriate water temperatures in resident care areas. Policy Explanation and Compliance Guidelines: ...5. Water temperatures will be set to a temperature of...100 degrees F to 120 degrees F, or the state's allowable...water temperature...." | | | |

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| | 3.1-19(r)(1)<br>3.1-19(r)(2) | | | |
| F 0641<br>SS=A<br>Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>Based on record review and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), for 1 of 16 MDS assessments reviewed (Residents 14).<br><br>Finding includes:<br><br>Resident 14's record was reviewed, on 4/5/23 at 8:29 a.m. The census information indicated the resident was admitted to the facility, on 1/2/23, with diagnoses included, but were not limited to, lumbar spondylosis with myelopathy (a condition that causes slow degeneration of the spine) and a pressure ulcer (damage to an area of the skin and underlying tissue resulting from prolonged pressure on the skin).<br><br>An activities of daily living care plan, initiated on 1/2/23 and revised on 4/3/23, indicated Resident 14 required staff assistance for bed mobility, locomotion, bathing/showering, oral care, and personal hygiene, with the care plan goal of the resident would have care needs met daily with assistance of the staff.<br><br>A care plan, initiated on 1/2/23 and revised on 4/3/23, indicated Resident 14 was admitted to the | F 0641 | **F641 Assessments**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>Resident #14's MDS was corrected -------4.26.2023 to reflect the proper status of pressure ulcer on admission to facility<br>Residents #14's MDS was corrected 4.26.2023 to reflect resident preferences.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>All residents that reside in the facility have the potential to be affected by the alleged deficient practice.<br>All MDS assessments will be reviewed for accuracy by the MDS Coordinator prior to submission.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>The MDS Coordinator was educated on 4.25.2023 by the | 05/01/2023 |

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| | facility with an unstageable pressure ulcer (wound with full thickness tissue loss in which actual, depth of the ulcer is completely obscured by slough [yellow, tan, grey, green, or brown tissue]) to the left heel.<br><br>An admission Minimum Data Set (MDS) assessment, dated 1/9/23, indicated the resident was cognitively intact; required extensive assistance of two staff for bed mobility, total dependence of two staff for transfers and bathing, and extensive assistance of one staff for personal hygiene and dressing; Resident 14 did not have a pressure ulcer; and the resident's preferences were not assessed in Section F of the MDS assessment.<br><br>On 4/6/23 at 9:21 a.m., the MDS Coordinator indicated, Section F of the resident's preferences should have been completed by the activity director and Resident 14 had a pressure ulcer upon admission and the pressure ulcer should have been documented on the admission MDS assessment Section M. It just got missed.<br><br>The MDS Coordinator, on 4/6/23 at 9:43 a.m., provided and identified a document as a current facility policy titled, "CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2019. The policy indicated, "...Section F: Preferences for Customary Routine and Activities...Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this | | Regional MDS Consultant on proper MDS coding according to the RAI manual.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**<br>QAPI tool MDS Accuracy will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. | |

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| | interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive...Section M: Skin Conditions...Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries...A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program...M0100: Determination of Pressure Ulcer/Injury Risk...Coding Instructions...Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review...."<br><br>3.1-31(a) | | | |
| F 0655 SS=D Bldg. 00 | 483.21(a)(1)-(3)<br>Baseline Care Plan<br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders. | | | |

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| | (C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br><br>Based on record review and interview, the facility failed to ensure a baseline care plan was developed for the diagnosis of dementia and the baseline care plan for rehabilitation potential and special services was accurate for 1 of 3 new admission residents' care plans reviewed (Resident 96).<br><br>Finding includes:<br><br>Resident 96's record was reviewed on 4/4/23 at | F 0655 | F Care Plan<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient Resident #96 care plan was corrected on 4.26.2023 to reflect that resident does not receive hospice services or dialysis service. Resident #96 care plan was updated on 4.26.2023 to include dementia diagnosis. How other residents | 05/01/2023 |

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| | 9:55 a.m. Census information indicated the resident was admitted to the facility, on 3/30/23, with diagnoses included, but not limited to, dementia (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and cerebral palsy (condition marked by impaired muscle coordination [spastic paralysis] typically caused by damage to the brain before or at birth).<br><br>Review of Resident 96's care plans lacked documentation a dementia care plan had been created and the rehabilitation potential and special services care plan indicated the resident was receiving hospice (end of life care) and dialysis (process of removing excess water, solutes, and toxins from the blood in persons whose kidneys can no longer perform these functions naturally) services.<br><br>During an interview, on 4/4/23 at 11:20 a.m., the Social Services Director (SSD) indicated Resident 96 should have a dementia care plan, since the resident had a dementia diagnosis. The resident was not receiving hospice service nor dialysis service and the services should not have been added to the resident's care plan. The services were added to the care plan by mistake.<br><br>On 4/4/23 at 12:28 p.m., the Director of Nursing (DON) provided and identified a document as a current facility policy, titled "Care Planning - Interdisciplinary Team," dated 9/28/17. The policy indicated, "...3. A baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care...."<br><br>3.1-35(b)(1) | | having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in facility have the potential to be affected by the alleged deficient practice. A facility wide care plan audit was completed on 4.26.2023 to ensure all resident diagnosis were updated within the last 90 days. A facility wide care plan audit was completed on 4.26.2023 to ensure all residents interventions are appropriate within the last the 90 days. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; MDS coordinator/designee was educated on 4/25/23 by the DNS/Designee on ensuring all appropriate diagnosis are added to baseline care plan. MDS coordinator/designee was educated on 4/25/23by the DNS/designee on ensuring all interventions are individualized and up to date on care plan. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; QAPI tool Care Plan will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee. If 100% threshold is not achieved an action plan will be developed. This | |

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| | 3.1-35(d)(2)(B) | | information will be presented to the QAPI committee during the monthly meeting. | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review, the facility failed to ensure care plan meetings were conducted for 1 of 16 residents reviewed for timing of care plan meetings (Resident 27). | F 0657 | F657 Care Plan Timing/Revision<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #27 | 05/01/2023 |

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| | 155358 | A. BUILDING 00<br>B. WING | 04/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| MAJESTIC CARE OF DEMING PARK | 3300 POPLAR ST<br>TERRE HAUTE, IN 47803 |

| (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 |
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| | Findings include:<br><br>During an interview, on 4/3/23 at 10:36 a.m., Resident 27 indicated she could not remember ever attending a care plan meeting. She was unsure if her nephew had attended, but he had not mentioned anything about it and he doesn't live in town.<br><br>Resident 27's record was reviewed on 4/4/23 at 9:51 a.m. The profile indicated resident's diagnoses included, but were not limited to, bilateral (both) primary osteoarthritis of knee (wearing down of the protective tissue at the ends of bones), muscle weakness, hypertension (elevated blood pressure), and unspecified dementia (mental disorder in which a person loses the ability to think, remember, learn, make decision, and solve problems).<br><br>An Annual Minimum Data Set (MDS) assessment, dated 1/12/23, indicated the resident had a moderate cognitive impairment.<br><br>A care plan, with an initiated date of 5/27/21 and an expired goal date of 7/1/23, indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs.<br><br>During an interview on 4/5/23 at 8:39 a.m., the Social Service Director (SSD) indicated she had forgotten to open the interdisciplinary team (IDT) note for the care plan meetings. She was unable to provide documentation that a care plan meeting had been conducted for Resident 27. The SSD further indicated Resident 27's family member was not involved in her care and did not attend care plan meetings.<br><br>On 4/4/23 at 12:28 p.m., the Director of Nursing | | and her responsible party were invited to a care plan conference on 4.5.2023 by the Executive Director/Designee. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br><br>All residents in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was completed on 4.26.2023 to ensure that all residents and /or responsible parties have been offered a care plan meeting within the last. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Care plan invitations will be sent based on the MDS assessment schedule to the responsible party and/or resident every quarter. Copies of the will be kept. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; QAPI tool Care Plan will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Social Service/Designee. If % threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly | |

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| MAJESTIC CARE OF DEMING PARK | 3300 POPLAR ST<br>TERRE HAUTE, IN 47803 |

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| | (DON) provided a document, with a revised dated of 9/28/17, titled, "Care Planning-Interdisciplinary Team" and indicated it was the policy currently being used by the facility. The policy indicated, " ...6. Every effort will be made to schedule care plan meeting at the best time of date for the resident and family ...."<br><br>3.1-35(c)(2)(B) | | meeting. | |
| F 0689 SS=E Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to ensure hot water temperatures were maintained within safe range for 3 of 3 residents reviewed for accidents (Residents 17, 97, and 196).<br><br>Findings include:<br><br>1. During an observation on 3/31/23 at 2:27 p.m. Resident 17's bathroom sink was too hot to hold hands under the water for more than a few seconds without burning the skin.<br><br>Resident 17's record was reviewed on 4/5/23 at 1:09 p.m. An admission Minimum Data Set (MDS) assessment, dated 3/9/23, indicated Resident 17 had a moderate cognitive impairment and required a one-person physical assist with bed mobility, | F 0689 | F 689 Free from Incidents/Accidents<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Mixing valve was replaced on 4-6-23. 2” water line repaired from the water heater and the ball valve was adjusted. The ball valve was found to be opened too far during last repair by Gibson CO on 04.06.23 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective | 05/01/2023 |

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| | transfers, and toilet use.<br><br>The profile indicated the resident's diagnoses included, but were not limited to, congestive hear failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypoxemia (a low level of oxygen in the blood), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and left humerus (bone in upper arm) facture.<br><br>During an interview on 3/31/23 at 2:27 p.m., Resident 17 indicated he had noticed the water temperature was often too hot and he would have to turn on the cold water to mix with the hot water. He further indicated he had not told anyone about the hot water temperature.<br><br>2. During an observation on 3/31/23 at 2:50 p.m., Resident 97's bathroom sink was too hot to hold hands under the water for more than a few seconds without burning the skin. The Administrator (ADM) checked the water temperature on 3/31/23 at 3:00 p.m., and indicated that she could feel the heat on the pipe of the bathroom sink. The facility's thermometer indicated a temperature of 133 degrees Fahrenheit (F). The ADM indicated the temperature was too hot and should be less than 120 degrees F.<br><br>Resident 97's record was reviewed on 4/5/23 at 2:57 p.m. An admission MDS assessment dated 3/17/23, indicated Resident 97 had a moderate cognitive impairment and requires a one-person physical assist with his activities of daily living.<br><br>The profile indicated the resident's diagnoses included, but were not limited to, cerebral infarction (result of disrupted blood flow to the | | action(s) will be taken;<br><br>Residents that reside in the facility have the potential to be affected by the alleged deficient practice. No negative outcomes in any room affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director educated on appropriate and safe water temps for facility on 4-25-2023. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Water temperature checks daily x 4 weeks, daily x 2 weeks, then weekly by maintenance director/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting. | |

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| | brain due to problems with the blood vessels that supply it), rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein in the blood), dysphagia (difficulty swallowing), and chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body).<br><br>During an interview on 3/31/23 at 2:50 p.m., Resident 97 indicated he required assistance for all his care from staff and he did not use his bathroom sink.<br><br>3. During an observation on 3/31/23 at 2:55 p.m., Resident 196's bathroom sink was too hot to hold hands under the water for more than a few seconds without burning the skin. The ADM checked the water temperature on 3/31/23 at 3:02 p.m., the facility's thermometer indicated a temperature of 129.8 degrees F. The ADM indicated the temperature was too hot and should be less than 120 degrees F.<br><br>Resident 196's record was reviewed on 4/5/23 at 2:09 p.m. An admission MDS assessment, dated 3/27/23, indicated Resident 196 was cognitively intact and requires a two-person physical assist for all his activities of daily living.<br><br>The profile indicated resident's diagnoses included, but were not limited to, facture of sacrum (break of the shield shaped bony structure that is located a the base of the lumber vertebrae that is connect to the pelvis), end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long term dialysis), paroxysmal atrial fibrillation (a heart's upper chambers beat our of coordination | | | |

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| | with the lower chambers), and type II diabetes (a chronic condition that affects the way the body processes blood sugar).<br><br>During an interview on 3/31/23 at 2:55 p.m., Resident 196 indicated he requires assistance for his care from staff and he did not use his bathroom sink.<br><br>During an interview, on 3/31/23 at 3:00 p.m., the ADM indicated she was not aware of the maintenance supervisor working on anything in the facility dealing with hot water temperatures. She indicated he randomly checked hot water temperatures weekly throughout the facility. She further indicated they had replaced the hot water heater about a year ago.<br><br>During an interview, on 3/31/23 at 3:17 p.m., the ADM indicated she had called the heating and cooling company and they would be on their way to assess the hot water temperatures. She indicated the maintenance supervisor would be coming back to the facility to check the hot water temperatures with the facility thermometer. She further indicated the staff would not be giving showers until the water was within a safe temperature range.<br><br>The Maintenance supervisor provided a hot water temperature log dated 3/31/23 at 5:30 p.m., the log indicated several rooms throughout the facility had elevated hot water temperatures. The log indicated the following:<br><br>a. Room 110's bathroom sink hot water temperature measured 122 degrees F.<br>b. Room 115's bathroom sink hot water temperature measured 129 degrees F.<br>c. Room 116's bathroom sink hot water | | | |

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| | temperature measured 131 degrees F.<br>d. Room 117's bathroom sink hot water temperature measured 127 degrees F.<br>e. Room 119's bathroom sink hot water temperature measured 122 degrees F.<br>f. Room 123's bathroom sink hot water temperature measured 125 degrees F.<br>g. Room 227's bathroom sink hot water temperature measured 126 degrees F.<br>h. Room 229's bathroom sink hot water temperature measured 121 degrees F.<br>i. Room 233's bathroom sink hot water temperature measured 130 degrees F.<br><br>During an interview, on 4/3/23 at 1:39 p.m., the maintenance supervisor indicated the heating and cooling company had ordered a new mixing valve and the new valve would be at facility on 4/4/23.<br><br>During an interview, on 4/4/23 at 2:00 p.m., the ADM indicated the heating and cooling company was at facility to replace the mixing valve.<br><br>On 4/3/23 at 9:30 a.m., the maintenance supervisor provided a document, with a revised date of December 2009, titled, "Water Temperatures, Safety of," and indicated it was the policy currently being used by the facility. The policy indicated, " ... 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperature of no more than 120 F ...."<br><br>3.1-45(a)(1)<br>3.1-45(a)(2) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility | | | |

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| MAJESTIC CARE OF DEMING PARK | 3300 POPLAR ST<br>TERRE HAUTE, IN 47803 |

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| | must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>Based on observation, interview, and record review, the facility failed to ensure opened insulin vials and an insulin pen were not stored past their expiration date for 2 of 2 medication carts reviewed for medication storage.<br><br>Findings include:<br><br>On 4/6/23 at 8:45 a.m., the 100-hall medication cart was observed to have a multi dose insulin vial, dated 3/4/23, and multi dose vial, dated 2/23/23, and an opened insulin pen without a medication label, no date opened, or a resident name recorded on the insulin pen. | F 0761 | F761 Label/Store Drugs and Biologicals<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Expired insulin vials and pen was removed 04.06.23 from 100 and 200 medication cart. Insulin pen found unlabeled was provided a medication label by pharmacy consultant in facility. How other residents having the potential to be affected by the same deficient practice will be identified and what | 05/01/2023 |

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| | During an interview, on 4/6/23 at 8:55 a.m., Licensed Practical Nurse (LPN) 18 indicated, the facility policy for expired insulin vials and insulin pens was 30 days, and the insulin pen should have had a label with the resident's name and an opened date. LPN 18 indicated the two vials of expired insulin had been administered 4/6/23 and the insulin pen was for Resident 8 and should have had the resident's name and a date opened.<br><br>On 4/6/23 at 9:05 a.m., the 200-hall medication cart was observed with an insulin pen with a date opened on 3/9/23. During interview with LPN 19 indicated the expiration date for the opened insulin vials and pens was 30 days and the pen insulin had been administered on 4/6/23.<br><br>On 4/6/23 at 1:40 p.m., the Regional Nurse Consultant provided and identified a document as a current facility policy, titled "Medication Administration Expiration Dating," dated 10/30/18. The policy indicated, "...Procedure: ...d. ii, Multidose vials that have been opened or accessed should be dated when opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for opened vial...."<br><br>3.1-25(j)<br>3.1-25(m)<br>3.1-25(n) | | corrective action(s) will be taken; All residents that reside in facility have the potential to be affected by the alleged deficient practice. All medication and treatment have been audited on 4.24.2023 to ensure there is no expired insulin. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All licensed nurses were educated on 4.25.2023 the understanding of expiration dates for insulin and that all medication must have a label from pharmacy with resident information and expiration date. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; QAPI tool Medication Storage will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee. If % threshold is not achieved an action plan will be developed. | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources | | | |

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| | approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and record review, the facility failed to obtain refrigerator and freezer temperatures for 7 out of 7 logs observed during the initial kitchen tour and the facility failed to ensure proper handling of food during 1 of 2 dining observations.<br><br>Findings include:<br><br>1. During an initial tour observation of the kitchen with the Dietary Manager (DM), on 3/31/23 at 9:56 a.m., there was missing temperatures and staff initials on the refrigerator and freezer logs for 7 out of 7 logs posted on the refrigerators and freezers. The DM indicated dietary staff should be obtaining and recording temperatures for refrigerators and freezers twice daily, once on day shift and once on evening shift. She indicated the logs were incomplete and had holes.<br><br>On 3/31/23 at 10:18 a.m., the DM provided equipment temperature logs for the month of | F 0812 | F812 Food /Prepare/Serve-Sanitary<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All refrigerator and freezer temperature logs were audited on 4.26.2023 for completion.<br>LPN #7 was educated by DNS/Designee 4.27.2023 on proper handling of food during dining service. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in facility have the potential to be affected by the alleged deficient practice. Dietary Manager/Designee was educated | 05/01/2023 |

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| | March. The logs indicated the following:<br><br>a. Supplement Freezer, the record lacked documentation that a temperature had been measured on 3/4 during dayshift. The record lacked documentation that the temperatures had been measured on 3/24, 3/25, 3/26, 3/27, 3/28, and 3/29 for evening shift.<br><br>b. Prep Reach in refrigerator, the record lacked documentation that a temperature had been measured on 3/4 during dayshift. The record lacked documentation that the temperatures had been measured on 3/24, 3/25, 3/26, 3/27, 3/28, and 3/29 for evening shift.<br><br>c. Potato Freezer, the record lacked documentation that a temperature had been measured on 3/4 and 3/14 during dayshift. The record lacked documentation that the temperatures had been measured on 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, and 3/30 for evening shift.<br><br>d. Vegetable Freezer, the record lacked documentation that a temperature had been measured on 3/4 and 3/14 during dayshift. The record lacked documentation that the temperatures had been measured on 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, and 3/30 for evening shift.<br><br>e. Ice Cream Freezer, the record lacked documentation that a temperature had been measured on 3/4, 3/14, and 3/19 during dayshift. The record lacked documentation that the temperatures had been measured on 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, and 3/30 for evening shift. | | 4.25.2023 on the process for temperature monitoring for supplemental freezer, prep reach refrigerator, potato freezer, vegetable freezer, ice cream freezer, pie freezer, and walk in refrigerator. All staff have been educated by DNS/designee on proper handling of food during dining service 4.25.2023. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff were educated on 4.26.2023 for appropriate process of documenting temps for all refrigerator/freezer twice daily. Refrigerator and Freezer Temps will be audited 5 days per week in the morning to ensure documentation of the temps have occurred per the Dietary Manager/Designee. Room Service tool will be completed 5 days a week to ensure proper handling of food is being conducted by Director/Designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; QAPI tool Dining Services will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee. If % threshold is not achieved an action plan will be developed. This information will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155358 | A. BUILDING 00<br>B. WING | 04/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MAJESTIC CARE OF DEMING PARK | 3300 POPLAR ST<br>TERRE HAUTE, IN 47803 |

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|---|---|---|---|---|
| | f. Pie Freezer, the record lacked documentation that a temperature had been measured on 3/14 and 3/19 during dayshift. The record lacked documentation that the temperatures had been measured on 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, and 3/30 for evening shift.<br><br>g. Walk in refrigerator, the record lacked documentation that a temperature had been measured on 3/4 and 3/20 during dayshift. The record lacked documentation that the temperatures had been measured on 3/21, 3/22, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, and for evening shift.<br><br>On 3/31/23 at 10:18 a.m., the DM provided a document, dated October 2018, titled, "Equipment Temperature and Monitoring," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Temperatures of refrigeration/freezer equipment will be monitored twice per day ... Thermometers in each location will be checked twice daily and recorded on the equipment monitoring log ...."<br><br>2. During a dining observation, on 3/31/23 at 12:18 p.m., LPN 7 served a resident her tray of food. LPN 7 picked up the resident's sandwich bun with bare hands and placed a condiment on her sandwich. LPN 7 then placed the bun back on the resident's sandwich with bare hands.<br><br>During an interview, on 4/4/23 at 2:11 p.m., the DM indicated staff should not be touching residents food with their bare hands.<br><br>On 4/4/23 at 2:50 pm., the DM provided a document, with a revised date of April 2019, titled, "Food Service/Distribution," and indicated it was | | be presented to the QAPI committee during the monthly meeting. Refrigerator and Freezer temperature logs will be audited daily x 4 weeks, bimonthly x 2 and monthly x 4 months by Dietary Manager/designee. If 100% threshold is not action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. | |

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| | 155358 | A. BUILDING 00<br>B. WING | 04/06/2023 |

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| | the policy currently being used by the facility.<br>The policy indicated, " ...6. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks ...."<br><br>3.1-21(i)(3) | | | |