

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2024
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155207 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/16/2024 | |
| NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NEW HAVEN | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DRIVE NEW HAVEN, IN 46774 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 000 | INITIAL COMMENTS This visit was for the Investigation of Complaints IN00424696 and IN00424931. Complaint IN00424696 - No deficiencies related to the allegations are cited. Complaint IN00424931 - No deficiencies related to the allegations are cited. Survey date: January 16, 2024. Facility number: 000114 Provider number: 155207 AIM number: 100266640 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 3 Medicaid: 56 Other: 27 Total: 86 Majestic Care New Haven was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00424696 and IN00424931. Quality review completed January 16, 2024 | | | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.