STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING _____ B. WING _____	C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF LAFAYETTE	**300 WINDY HILL DR LAFAYETTE, IN 47905**

(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 IN00417939, IN00420584, IN00423639, IN00423923, IN00425302, IN00425739, IN00426095 and IN00427005. Complaint IN00417939- No deficiencies related to the allegations are cited. Complaint IN00420584- No deficiencies related to the allegations are cited. Complaint IN00423639- No deficiencies related to the allegations are cited. Complaint IN00423923- No deficiencies related to the allegations are cited. Complaint IN00425302- No deficiencies related to the allegations are cited. Complaint IN00425739- No deficiencies related to the allegations are cited. Complaint IN00426095- No deficiencies related to the allegations are cited. Complaint IN00427005- No deficiencies related to the allegations are cited. Survey dates: January 24, 25, 26 and 29, 2024 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Census Bed Type: SNF/NF: 90	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING _____ B. WING _____	C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF LAFAYETTE	**300 WINDY HILL DR LAFAYETTE, IN 47905**

(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	Continued From page 1 Total: 90 Census Payor Type: Medicare: 10 Medicaid: 77 Other: 3 Total: 90 Majestic Care of Lafayette 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 IN00417939, IN00420584, IN00423639, IN00423923, IN00425302, IN00425739, IN00426095 and IN00427005. Quality review was completed on February 2, 2024.	F 000		