STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING 01 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

(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
K 0000 Bldg. 01	An investigation of Complaint Number IN00456495 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Complaint Number #IN00456495 - A Federal/State deficiency related to the allegation was cited at K741. This visit was in conjunction with the Life Safety Code Recertification Post Survey Revisit (PSR) that exited on 04/02/25. Survey Date: 04/02/25 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Complaint survey, Majestic Care of Haven Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility is partially protected by a Type II EES 60KW diesel powered generator. The facility has a capacity of 120 and had a census of 70 at the time	K 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorri Maples	Administrator	04/18/2025

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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	of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered which the exception of a detached building housing the emergency generator and used for storage of maintenance equipment. Quality Review completed on 04/04/25			
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Based on records review and interview, the facility failed to follow 1 of 1 smoking policy procedures to ensure residents that require staff supervision were properly and safely supervised. This deficient practice affects all residents. Findings include: Based on records review of the incident intake with the Administrator, the Director of Nursing (DON), and the Maintenance Director on 04/02/25 at 12:30 p.m., reported: "Staff noticed a burnt smell when walking by resident room 201 and when they entered the room, smoke was coming from the trash can but no flames. The nurse immediately took the trash can to the shower room across the hall and sprayed it with water. No cigarette butts were found in the trash can. No lighter or other smoking materials were found in the resident's room. No damage to the room was found. The Administrator spoke with resident #1 regarding the incident. When asked what happened, resident #1 forgot to throw away the butt and had put it in her pocket. resident #1 went	K 0741	1 Immediate action(s) taken for the resident(s) found to have been affected include: Resident #1 room was assessed for any damages and safely returned to the room same day Resident #1 was reassessed for safe smoking on 3/31/25. Residents who smoke met with the Administrator on 3/31/25 to review the smoking policies and emphasize safety. The Administrator reviewed proper disposal of smoking materials in the ash cans provided and that no smoking materials are to be in resident rooms at any time. 2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:**	05/02/2025

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	in her room and saw it was in her pocket and put it in the trash can. Resident #1 said she didn't realize it was still hot. Based on records review of the smoking policy with a review date of 02/14/25 at 12:40 p.m., stated residents may smoke in designated smoking areas and residents will be routinely assessed to determine if the resident requires supervision while smoking. Based on an interview at 12:45 p.m., the Administrator agreed with the aforementioned documentation, and stated resident #1 was assessed, requires supervision, and resident #1 was not properly supervised during the smoke break. This finding was reviewed with the Administrator, the DON and Maintenance Director during the exit conference at 1:40 p.m., 3.1-19(b) This federal tag relates to complaint number IN00456495.		Employees who supervise resident smokers were in-serviced regarding the facility policy for supervising residents while smoking and ensuring all smoking material is disposed of properly on 4/3/25. A check-off sheet will be used by staff who supervise residents at smoke times, to ensure smoking materials are accounted for, for each resident and properly disposed of. Residents who smoke met with the Administrator on 3/31/25 to review the smoking policies and emphasize safety. Reviewed proper disposal of cigarette butts in the ash cans provided and that no smoking materials are to be in resident rooms at any time. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** Smoking assessments were completed for all residents who currently smoke. A check-off sheet will be used by staff who supervise residents at smoke times, to ensure disposal of smoking materials is accounted for, for each resident smoking, and properly disposed of. The facility will ensure staff and residents adhere to established smoking policies and procedures.	

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			Smoking materials are discarded properly in areas where smoking is permitted and not permitted. The Administrator and/or designee will monitor smoking areas and nonsmoking areas, ongoing, to ensure proper disposal of discarded smoking materials and ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. Records will be reviewed by the Safety Committee ongoing.	