STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. BUILDING 00 B. WING	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF BEDFORD	2111 NORTON LN BEDFORD, IN 47421

(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. This visit included the Investigation of Complaint IN00455844. Complaint IN00455844 - No deficiencies related to the allegations are cited. Survey dates: March 24 - 28, 2025 Facility number: 000040 Provider number: 155100 AIM number: 100274460 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 8 Medicaid: 87 Other: 7 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 1, 2025.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. The plan of correction is prepared and executed solely because it is required by the position of federal and state law. The plan of correction is submitted to respond to the allegation of noncompliance cited during an annual survey. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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 written notification required for a transfer and discharge was provided to the resident and the resident representative for 2 of 3 residents reviewed for hospitalization. (Resident 41, Resident 74)	F 0623	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	04/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Swaby	Executive Director	04/11/2025

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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	Findings include: 1. Resident 74's clinical record was reviewed on 3/27/25 at 10:27 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and dementia. Resident 74's progress notes indicated the resident was sent to the hospital on 12/6/24. The clinical record lacked documentation of written notification of the transfer and discharge forms having been provided to the resident representative. During an interview on 3/27/25 at 11:30 a.m., the Administrator indicated the facility did not have documentation which indicated the transfer and discharge forms were provided in writing to Resident 74's representative. 2. Resident 41's clinical record was reviewed on 3/27/25 at 2:54 p.m. The diagnoses included, but were not limited to, dementia and repeated falls. Resident 41's progress notes indicated the resident was sent to the hospital on 2/19/25. The clinical record lacked documentation of written notification of the transfer and discharge forms having been provided to the resident and to the resident representative. During an interview at 3/28/25 at 12:27 p.m., the Director of Nursing indicated the facility did not have documentation which indicated the transfer and discharge forms were provided in writing to Resident 41 and to the resident representative. On 3/28/25 at 3:29 p.m., the Director of Nursing provided the facility's policy,"Transfer and		Staff reviewed the records of resident's 74 and 41. The transfer/discharge notice was sent to the resident/responsible party on 4/1/2025. **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 have the potential to be affected by the alleged deficiency. No other residents were noted to be affected by the alleged deficiency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed Nursing staff were educated on 3/31/25 on the transfer/discharge policy (exhibit A) per the Director of Nursing Services/Designee. Copies of the Transfer/Discharge packet (Exhibit B) are on the stations for nursing to complete during a transfer. Completion of the transfer/discharge packet will be monitored in morning meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	Discharge" dated, 12/12/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 4. the facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand ..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		**assurance program will be put into place;** and The IDT team will utilize the audit tool titled “Transfers and Bedholds” (Exhibit C) to audit 5 transferred residents weekly for 4 weeks, audit 5 transfers monthly x 2 months, and audit 5 transfers quarterly x 3 quarters. Audits have been completed for 4/2/25 and 4/9/25. The audits will be submitted to the Quality Assurance Committee for review. The audits will be submitted until substantial compliance is achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed;** 4/2/2024	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 1 of 3 residents reviewed for hospitalization. (Resident 41) Findings include: Resident 41's clinical record was reviewed on 3/27/25 at 2:54 p.m. The diagnoses included, but	F 0625	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Staff reviewed the records of resident’s 74 and 41. The bedhold policy, was sent to the resident/responsible party on 4/1/2025.	04/02/2025

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	were not limited to, dementia and repeated falls. Resident 41's progress notes indicated the resident was sent to the hospital on 2/19/25. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy was provided to the resident or the resident representative. During an interview at 3/28/25 at 12:27 p.m., the Director of Nursing indicated the facility did not have documentation which indicated the bed-hold policy was provided in writing to Resident 41 or to the resident representative. On 3/28/25 at 3:29 p.m., the Director of Nursing provided the facility's policy,"Bed Hold" dated, 12/12/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed ..." 3.1-12(a)(25) 3.1-12(a)(26)		**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 have the potential to be affected by the alleged deficiency. No other residents were noted to be affected by the alleged deficiency **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed Nursing staff were educated on 3/31/25 on the Bedhold Policy (Exhibit B pages 4 and 5) per the Director of Nursing Services/Designee. Copies of the Transfer/Discharge packet (Exhibit B) are on the stations for nursing to complete during a transfer. Completion of the transfer/discharge packet will be monitored in morning meeting. **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; and** The IDT team will utilize the audit tool titled “Transfers and Bedholds” (Exhibit C) to audit 5	

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			transferred residents weekly for 4 weeks, audit 5 transfers monthly x 2 months, and audit 5 transfers quarterly x 3 quarters. Audits were completed on 4/2/25 and 4/9/25The audits will be submitted to the Quality Assurance Committee for review. The audits will be submitted until substantial compliance is achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed;** **4/2/2024**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to document and implement new interventions to prevent falls for 1 of 5 residents reviewed for accidents. (Resident 31) Findings include: On 3/27/25 at 11:20 a.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, rheumatoid arthritis, and peripheral neuropathy (weakness, numbness, and pain from nerve damage). The Quarterly MDS (Minimum Data Set) assessment, dated 2/24/25, indicated Resident 31 had severe cognitive impairment and had no falls	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 31's fall was reviewed by IDT. An IDT note and risk management were completed on 3/27/2025. An intervention was careplanned. **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;**	04/02/2025

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	since the prior assessment. The Care Plans included, but were not limited to: - At Risk for Falls, initiated on 10/30/24. The interventions included but were not limited to: Dycem between cushion and chair, dated 2/26/25. Encourage to go to dining room for meals, dated 2/10/25. Bed against the wall, dated 1/31/25. Mat between bed and wall, dated 1/31/25. Touch pad call light, dated 1/31/25. Encourage resident to sleep in bed at night, dated 12/26/24. If resident prefers to sleep in recliner staff will assist with raising foot of chair, dated 12/26/24. Non-skid strips to be placed in front of recliner, dated 12/13/24. Therapy to evaluate and treat as appropriate, dated 12/12/24. Encourage and assist to wear non-skid footwear, dated 10/30/24. Encourage to participate in activities that promote exercise and physical activity, dated 10/30/24. Follow facility fall protocol, dated 10/30/24. Keep call light and frequently used personal items within reach, dated 10/30/24. Therapy to screen quarterly and as needed, notify therapy of changes in gait or balance, dated 10/30/24. - Resident exhibits behavior symptoms of not asking for help when needing assistance, initiated on 3/24/25. The interventions included, but were not limited to: Assess residents needs, dated 3/24/25. Maintain a safe environment, dated 3/24/25. Provide positive feedback for good behaviors, dated 3/24/25.		All residents have the potential to be affected by the alleged deficient practice. No other residents were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing Services/designee will educate all licensed nursing staff on the *policies of "Fall Prevention" (Exhibit D) and "Documentation in the Medical Record" (Exhibit* E). Education was completed on 3/31/25 **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; and** The Director of Nursing Services/designee will utilize the audit tool "Fall Documentation" (Exhibit F). The audit will be completed 3 days a week for 1 month, weekly for 2 months and monthly for 3 quarters. Audits were completed on 4/2/25, 4/3/25, 4/4/25, 4/7/25, 4/9/25, and 4/11/25. The audits will be submitted to the Quality Assurance Committee for review.	

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	The nursing progress notes indicated the following: - On 3/16/25 at 8:33 p.m., Resident continues on neurological checks post fall this morning. Neurological checks within normal limits. Denies pain or discomfort. Has been in room all day. No distress noted. - On 3/17/25 at 10:42 a.m., resident continues with neurological checks due to fall on 3/16/25, vital signs within normal limits, no signs, symptoms, or complaints of pain at this time. - On 3/18/25 at 6:39 p.m., resident continues with neurological checks due to fall on 3/16/25, vital signs within normal limits, no signs, symptoms, or complaints of pain at this time. - On 3/19/25 at 6:26 p.m., resident continues on neurological checks this shift. Neurological checks within normal limits. Resident denies pain or discomfort. Walked to dining room for lunch and dinner. No distress. The clinical record for Resident 31 lacked documentation and new interventions for the fall on 3/16/25 until 3/24/25. During an interview with the DON on 3/27/25 at 2:15 p.m., she indicated that the fall was not documented in record and was not reported to her at that time. The DON indicated there was no IDT (interdisciplinary team) meeting completed until today, 3/27/25. During an interview with Resident 31's daughter on 3/27/25 at 3:00 p.m., she indicated she was notified on 3/16/25 of resident's fall.		The audits will be submitted until substantial compliance is achieved as determined by the Quality Assurance Team. **By what date the systemic changes for each deficiency will be completed;** 4/2/25	

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	On 3/28/25 at 3:20 p.m., the DON provided the facility policy, "Fall Prevention," dated 1/2/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...When any resident experiences a fall, the facility will: a. Assess the resident b. Complete a post-fall assessment c. Complete an incident report... d. Notify the physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions..." 3.1-45(a)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 1 of 2 kitchen observations. Food was not discarded by the discard date and food was stored under the condenser fan. This had the potential to affect 85 of 102 residents who were served food from the kitchen. Findings include: On 3/28/25 at 10:30 a.m., during a follow-up tour of the kitchen with the Dietary Manager (DM), the following was observed: - The walk in refrigerator had a container of liquid salad dressing with an open date of 1/12/25 and a discard date of 2/12/25. - The walk in freezer had an open box of cheddar biscuits directly under the condenser fan, there	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. Discard dates for food were reviewed and discarded as needed. Food products stored beneath the freezer fans were moved to another location in the freezer. **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 have the potential to	04/02/2025

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	was ice accumulation noted on the fan directly above the box of food. The biscuits were covered in a plastic bag inside of opened box. During an interview with the DM on 3/28/25 at 10:30 a.m., she indicated that all containers opened were good for 30 days, after 30 days they were to be discarded. The DM indicated that the container of salad dressing should have been discarded on 2/12/25. The DM indicated that food should not be stored directly under the condenser fan to allow for proper circulation and to protect food from contamination if the fan would leak. On 3/28/25 at 3:10 p.m., the Corporate Nurse Consultant provided the facility's policy, "Safe Food Handling," dated 3/1/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated "...a. Food items are placed into appropriate storage locations consistent with Food Code Guidelines and protected from contamination. b. Leftover foods will be protected, labeled and dated with date of original preparation and date of discard..." 3.1-21(i)(2) 3.1-21(i)(3)		be affected by the alleged deficient practice. Discard dates for food was reviewed and discarded as needed. Food Products stored beneath the freezer fans were moved to another location in the freezer. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Dietary Manager completed education with the dietary staff on 4/1/2025 for the “Safe Food Handling” (Exhibit G) policy. **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; and** The Audit Tool “Food Storage” (Exhibit H) will be utilized to determine compliance. The audits will be completed by the Dietary Manager /designee. The audits will be completed 5 times a week for 1 month, 3 times a week for 2 months, and weekly for 3 quarters. Audits have been completed on 4/2/25 and 4/9/25The audits will be submitted to the Quality Assurance Committee until substantial compliance is achieved as determined by the	

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			Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed;** 4/2/2025	