

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

PRINTED: 04/06/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155243</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2023</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MAJESTIC CARE OF LAFAYETTE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 WINDY HILL DR</b> <b>LAFAYETTE, IN 47905</b>			
(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	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00401155, IN00403208, IN00403951, IN00401914 and IN00400620. This visit was also included a COVID-19 Focused Infection Control Survey. This visit was also included a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00401155 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403208 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403951 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00401914 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00400620 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 15, 16, 20 and 21, 2023.</p> <p>Facility number: 000147 Provider number: 155243 AIM number: 100266900</p> <p>Census Bed Type: SNF/NF: 106 Total: 106</p> <p>Census Payor Type: Medicare: 15 Medicaid: 86 Other: 5 Total: 106</p>			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.

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

PRINTED: 04/06/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155243</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAJESTIC CARE OF LAFAYETTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 WINDY HILL DR</b> <b>LAFAYETTE, IN 47905</b>		
(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  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 IN00401155, IN00403208, IN00403951, IN00401914 and IN00400620 and the Covid 19 Infection Control Survey.  Quality review was completed on March 27, 2023.	F 000			