STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of New Haven	1201 Daly Drive New Haven, IN 46774

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview the facility failed to notify a family of transfer for 1 of 4 residents reviewed. (Resident 2)Findings include: Resident 2's record review began on 1/4/26 at 10:14 AM. Resident 2's diagnosis included history of myocardial infraction (heart attack), chronic obstructive pulmonary disease, and heart disease.A progress note, dated 10/26/25 at 10:15PM, indicated the resident was sent to ER for chest pain not relieved by Nitroglycerin tablet sublingual and per resident request. EMS was called.There were no progress notes to indicate Resident 2's emergency contact was notified of their trip to the Emergency Room. There was no note in the record to indicate Resident 2 did not want his emergency contact notified. Resident 2 was his own responsible party with his brother named as emergency contact.Resident 2's care plan indicated family was involved with the resident in the last 14 days yet did not indicate Resident 2 did not want brother involved in care or contacted in case of an emergency:Resident 2 indicated it was very important to choose what clothes he wore, to take care of his belongings, to choose the way he bathes, to have snacks available, to choose his own bedtime, and to have family or friends involved in his care plan. A review of Resident 2's care plans indicated there was no entries to address Resident 2 not wanting his emergency contact notified in case of an emergency. In an interview, on 1/7/26 at 10:24AM, the DON indicated Resident 2 did not wish for his brother to be notified. The DON indicated the wishes were in his care plan. In an interview, on 1/7/26 at 2:15PM, the Regional Nurse Consultant indicated Resident 2's brother was not notified due to Resident 2 being his own responsible party. A current policy and procedure were provided by DON on 1/8/26 at 11:31AM. The policy was titled Use and Disclosure of PHI for Facility Directories, Care Involvement, and Notification purposes dated 8/27/25 last revision date of 10/1/25. Involvement in Care and Notification a. We may disclose PHI directly relevant to a person's involvement in resident's/patient's care or payment, or to notify individuals of the patient's location, condition, or death. 3.1-5(a)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 2 residents reviewed (Resident 67).Findings included:During an interview on 01/07/2026 at 9:46 AM, Resident 67 indicated facility staff spoke with him inappropriately. Resident 67 indicated Licensed Practical Nurse (LPN) 9, Qualified Medication Aide (QMA) 10, and the Rehabilitation Director (RD) were present in his room that morning while discussing the condition of his room walls being half painted. Resident 67 indicated the RD stated she would submit a maintenance request. Resident 67 indicated he stated he had never lived in a place where the walls were half painted. Resident 67 indicated the RD stated how were the walls in prison. Resident 67 indicated prison was no place for a black educated man such as himself and indicated he had never been to prison. Resident 67 indicated the RD stated she was going to leave because she was outnumbered. Resident 67 indicated he interpreted this statement to mean the RD was leaving because she was the only white person in the room, as he, the LPN, and the QMA were black. During the interview, Resident 67's voice was raised and his eyes were glassy as he discussed the incident.During an interview on 01/07/2026 at 10:25 AM, the Director of Nursing (DON) indicated LPN 9 and QMA 10 informed her of comments made by the RD. The DON indicated the RD had been suspended pending investigation of the incident.During an interview on 01/08/2026 at 8:51 AM, LPN 10 indicated she was present in the room with Resident 67 and QMA 9. LPN 10 indicated the RD entered the room while she was completing rounds. LPN 10 indicated Resident 67 discussed his walls being half painted and that the RD stated she would submit a work order. LPN 10 indicated Resident 67 stated he had never been in a place where his room was not fully painted. LPN 10 indicated the RD stated you have been to prison. LPN 10 indicated Resident 67 stated prison was no place for an educated black man. LPN 10 indicated the RD stated well I am outnumbered I am going to go. LPN 10 indicated she interpreted this statement to mean the RD was leaving because she was the only white person in the room, as all others present were black.On 01/08/2026 at 1:30 PM, the DON provided a copy of the facility's investigation into the incident. The investigation file included the following statements:In a statement dated 1/7/2025 LPN 10 indicated while in the residents room, the RD from therapy entered the room and stated she need to complete room rounds for another manager. After she completed inspecting room she stated that she was going to write a maintenance request for residents room to be painted. The Resident stated that he has never been anywhere where his room hadn't been painted. The RD stated you have been to jail before. The Resident stated prison is no place for an educated black man. The RD continued to say I have to get out of here, I'm outnumbered. The RD then exited the room. The Resident stated he was very upset about the comments she made. In a statement, dated 1/7/2025, the RD indicated While covering room rounds this morning, Resident 67 was vocal about the condition of the walls in his room. When asked if maintenance request forms were filled out, she was told 3 requests were already completed and given to the Executive Director (ED) and maintenance. The resident made reference to being in prison. At which point she was uncomfortable with the conversation and excused herself from the room. She felt outnumbered being in the room as LPN 10 and QMA 9 were also in the room with the resident.In a statement, dated 1/7/2025, the Social Services Director (SSD) indicated on 1/7/26 around 9:00 a.m. she met with Resident 67. She asked him if anything had happened today to upset or bother him, and he stated that it did not. He stated that he was doing fine. He was laughing and smiling as we spoke. He said that someone made a comment that was racist. When I asked him to explain, he told me about how he had told staff member RD how much he did not like the fact his room is not fully painted. When he said this to the RD, she made a comment about something how he should see what it looks like in (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prison. He stated that staff member LPN 10 and QMA 9 were also in the room. RD made a comment that she was outnumbered. I asked him if she made the comment in a sarcastic or joking manner, and he said that she did.A review of Resident 67's current quarterly assessment indicated a Basic Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.A review of the facility's policy dated February 2018, provided by the DON, indicated Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g., using derogatory language. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability.This citation is related to Intake 2710550.3.1-27(b)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure pain management was provided for 1 of 3 residents reviewed (Resident 11). Findings included:Resident 11's record was reviewed on 1/4/2026. Diagnoses included pain in the right leg, other specified arthritis (unspecified site), primary osteoarthritis of the left elbow, primary osteoarthritis of the left shoulder, lumbago with sciatica, and systemic lupus erythematosus (unspecified).A review of physician orders, dated 11/10/2025 at 11:15 AM, indicated to give oxycodone-Acetaminophen Oral Tablet 7.5-325 MG 1 tablet by mouth every 8 hours as needed for severe pain greater then 7 on the pain scale. The order had a discontinued date of 12/18/2025.A review of physician orders dated 12/18/2025 at 12:30 PM indicated to give oxycodone-Acetaminophen Oral Tablet 7.5-325 MG 1 tablet by mouth every 8 hours as needed for severe pain greater than 7 on the pain scale.A review of Resident 11's current Care Plan indicated the resident was at risk of pain due to arthritis, lupus, and sciatica, with a goal date of 2/16/2026. Interventions included offering nonpharmacological interventions such as position changes, relaxation, a quiet environment, back rubs, and diversional activities.A review of Resident 11's Medication Administration Record (MAR), dated December 2025, indicated oxycodone-Acetaminophen Oral Tablet 7.5-325 MG was administered when the resident's pain level was less than 7 on the following dates: on 12/5/2025, Resident 11 reported a pain level of 4; on 12/7/2025, Resident 11 reported a pain level of 6; on 12/16/2025, Resident 11 reported a pain level of 6; and on 12/27/2025, Resident 11 reported a pain level of 6.A review of Resident 11's progress notes dated 12/5/2025, 12/7/2025, 12/16/2025, and 12/27/2025 was completed. No documentation of nonpharmacological interventions being provided was located in the notes.During an interview, on 1/7/2026 at 12:00 PM, the Director of Nursing (DON) indicated she could not find a reason why the oxycodone was administered for pain less than 7. The DON indicated the medication should not have been administered.A review of a current policy provided by the DON on 1/8/2026 at 10:06 AM indicated, Pharmacological interventions will follow a systematic approach for selecting medication and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain.3.1-37(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure collaboration with the off-site dialysis center for 1 of 1 resident reviewed (Resident 7).Findings included:Resident 7's record was reviewed on 01/04/2026 at 10:34 AM. Diagnoses included end stage renal disease and dependence on renal dialysis.A review of Resident 7's dialysis communication record indicated the pre-dialysis section did not include vital signs and was incomplete on 01/05/2026, 12/30/2025, 12/28/2025, 12/26/2025, 12/23/2025, 12/21/2025, 12/19/2025, 12/17/2025, and 12/10/2025.During an interview, on 01/07/2026 at 10:10 AM, Resident 7 indicated he took a folder to dialysis and inside it contained his medications and the dialysis communication form. Resident 7 indicated the facility did not always complete the form.During an interview, on 01/07/2026, the Director of Nursing (DON) indicated the facility did not complete the pre-dialysis section on the communication form as the facility had its own assessments. The DON indicated the assessment contained the same information and was sent with the resident to dialysis. The DON indicated the facility did not have a dialysis folder and instead sent a packet with the resident to each appointment. The DON indicated she did not have a way to demonstrate the facility sent the assessment, as the facility did not maintain a folder and sent the information in a packet.During an interview, on 01/08/2026 at 9:33 AM, the Dialysis Center Registered Nurse (RN) indicated Resident 7 routinely came to dialysis with a folder. The Dialysis Center RN indicated the facility often sent the dialysis communication sheet blank. The Dialysis Center RN indicated the section the facility was supposed to complete was often not filled out. The Dialysis Center RN indicated the facility did not send a separate facility assessment with the resident.A current policy dated July 2020, provided by the DON, indicated, Continued assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at an off-site dialysis center. Collaboration with the dialysis facility's plan of care. Appropriate paperwork as required by the off-site dialysis center will be sent with the resident.3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and record review the facility failed to ensure only current medications and medications with an open date were present in medication carts for 1 of 3 carts reviewed. Findings include: During an observation on 01/04/2026 at 11:08 AM, a bottle of medication was observed with the liquid level approximately 1.5 inches from the top of the bottle. The medication label had NOT OPEN in capital letters written in black marker. There was no open date on the bottle. Licensed Practical Nurse (LPN) 2 opened the lid. The inner seal was punctured with red liquid on the puncture and around inner part of lid. The multiple dose bottle was opened and some of the medication used. The medication was labeled with Resident 47's information. The medication was Guaifenesin liquid 100mg/5ml. The medication pharmacy label was dated 5/25/25 as being dispensed.Resident 47's record was reviewed on 1/4/26 at 11:22AM. Resident 47 did not have an active order for Guaifenesin liquid 100mg/5ml. In an interview, on 1/4/26 at 11:30 AM, the Director of Nursing (DON) indicated Resident 47 should have had an order for the medication but did not have one currently. A policy and procedure titled, Medication Storage provided by DON on 1/8/26 at 1:49PM, did not indicate what labeling practices should be.A policy and procedure titled, Labeling of Medication, review date 1/27/2025, was provided by the DON on 1/8/26 at 2:12PM. The policy indicated. 3) Multidose vials/devises should be labeled with date opened and or accessed. 3.1-25(j)(m)and(n)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review and interview the facility failed to ensure, dinning staff were following menu tickets for 4 of 4 residents reviewed. (Resident 46, Resident 49, Resident 63 and Resident 67)Findings include:During a dining observation on 01/04/2026 at 11:45 AM, it was observed Resident 63 and Resident 67 were not served broccoli salad on their lunch trays. A review of the residents' food tickets confirmed both individuals were scheduled to receive the broccoli salad as part of their meal.During a dining observation on 01/05/2026 at 12:02 PM, Resident 67 indicated he did not receive any garlic bread. He further stated that he frequently does not receive items listed on his meal ticket and that no substitutions are provided.A review of the food meal posting, dated 01/05/26, on 01/05/2026 12:08 PM, indicated garlic bread was listed. The sign was not modified to include a substitute if needed.A review of grievances on 1/8/26 at 12:20 PM indicated the following:A grievance related to Resident 46, dated 12/6/25, indicated she was having trouble with the lunch/dinning staff. The follow up indicated the dinning staff were not looking at her meal ticket and left food off of her meal tray.A grievance related to Resident 49, dated 10/27/25, indicated the resident was having issues with her meal trays (lunch and dinner). The findings indicated, dinning staff were not following the meal ticket. In a interview, on 1/6/26 at 1:25 PM, the Regional Nurse Consultant and Regional Dietary Manager, indicated dinning staff should look over the resident's diet and meal tickets to make sure they did not receive an item they should not get. A current facility policy, titled Menus, dated 1/2/24, was provided by the Director of Nursing on 1/8/26 at 10:06 AM. The policy indicated . Menus will be followed .Menus will consider the preferences of the resident population .the facility will determine an alternate menu/choices to accommodate resident choices/preference as possible 1.3-20(i)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure puree meals were consistently temperature-tested for 4 of 4 residents observed.Finding include:During an observation on 01/04/2026 at 11:38 AM, dietary staff was temping the food, and the puree broccoli temped at 130 F.In a interview, on 01/04/2026 at 11:38 AM, [NAME] 11 indicated the food was below temperature, then asked if she should place food back to be reheated. [NAME] 11 indicated, she would be placing food on the burner to cook. A record review of food temperature logs, dated December 2025 indicated the following:On 12/31/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/27/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/25/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/18/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/14/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/13/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/12/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/11/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/8/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.On 12/4/25, there was no temperature record for the breakfast puree, lunch puree, or dinner puree.In a interview, on 1/9/26 at 8:52 AM, the Director of Nursing indicated on these dates there were 4 residents ordered puree diets.A current facility policy, Safe food handling, dated 3/1/25, was provided by the Director of Nursing on 1/8/26 at 10:06 AM. The policy indicated .Will follow safe food handling to significantly reduced the risk for foodborne illness, thus strengthening the safety of the food provided to our residents/patients 1.3-21 (a)(1)(2)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, observation, and interview; the facility failed to ensure an effective process was in place to prevent recurrent medication storage concerns for 1 of 3 carts reviewed.Findings include: During an observation, on 01/04/2026 at 11:08 AM, a bottle of liquid medication was observed with the liquid level approximately 1.5 inches from the top if the bottle. The medication label had NOT OPEN in capital letters with black marker. There was no open date on the bottle. Licensed Practical Nurse (LPN) 2 opened the lid. A puncture to the inner seal was observed with red liquid on the puncture and around inner part of lid. The multiple dose bottle was opened and used. Resident 47's record was reviewed on 1/4/26 at 11:22AM. The medication was discontinued and did not have an active order. The open bottle of a multiple dose container without an open date prompted a citation of F0761. The [NAME] Report for the facility was reviewed on 1/4/26 at 8:52AM. The report indicated the facility was cited for F0761 Labeling/Store Drugs and Biologicals on the following dates 07/2022, 05/2023, 03/2024 and 1/2025. In an interview, on 1/9/26 at 10:04AM, the Director of Nursing (DON) indicated the facility did not have a current improvement plan for medication storage. The DON indicated the facility did cart audits Monday through Friday for expired medications, medications without an open date, and for any loose pills in the cart. The DON indicated they did cart to Medication Administration Record (MAR) audits weekly to ensure there were no medications in the cart that did not belong. The DON indicated the facility did audits and reported the results in their Quality Assurance Performance Improvement (QAPI) meetings.