

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Bedford		STREET ADDRESS, CITY, STATE, ZIP CODE 2111 Norton LN Bedford, IN 47421	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse when a severely cognitively impaired male resident grabbed another female resident by the hair, grabbed female resident's face causing a scratch, and slapped resident in the face and pushed on their eyes causing a corneal abrasion for 3 of 3 residents reviewed for abuse. (Resident B, Resident D, Resident E, Resident F)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 6/25/25 at 8:42 a.m. The diagnoses included, but were not limited to, chorea (a neurological disorder that causes involuntary, random, and continuous muscle movements while awake), cerebral palsy, anxiety disorder, and autistic disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 4/22/25, indicated Resident B was severely cognitively impaired and displayed verbal and physical behavioral symptoms directed towards others.</p> <p>A progress note, dated 6/8/25 at 2:11 p.m., indicated Resident B walked over toward the nurse's desk and as he walked by Resident D, Resident B reached over and grabbed Resident D's hair with both hands and would not let go. It took two staff members to redirect him.</p> <p>A progress note, dated 6/10/25 at 10:39 a.m., indicated Resident B was walking across the dining room with the CNA that was assigned to provide one-on-one supervision for Resident B that shift. As Resident B passed by Resident D, Resident B reached out and grabbed Resident D's arm with his left hand and then reached out with his right hand and grabbed Resident D's hair. Resident B would not let go of Resident D's hair. It took four people to separate and redirect Resident B.</p> <p>A progress note, dated 6/19/25 at 7:50 p.m., indicated Resident B reached out to adjust Resident E's face. In doing so, a scratch was made under Resident E's eye.</p> <p>A progress note, dated 6/20/25 at 4:35 p.m., indicated Resident B went into Resident F's room and poked Resident F in the eye leaving a scratch. When CNA 2 attempted to redirect Resident B, he began open handed slapping Resident F in the face. Resident F had swelling and redness to the left eye and bleeding in his mouth.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. During an interview on 6/25/25 at 10:47 a.m., Licensed Practical Nurse (LPN) 1 indicated there were two times when Resident B grabbed Resident D by the hair and wouldn't let go. One time Resident D was sitting in her wheelchair and Resident B walked over and grabbed her hair. It took a few staff to separate Resident B from Resident D's hair. Each time this happened Resident D had cried and the first time she complained of pain.</p> <p>The clinical record for Resident D was reviewed on 6/25/25 at 1:02 p.m. The diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy and autistic disorder.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident D was severely cognitively impaired.</p> <p>A progress note, dated 6/8/25 at 2:34 p.m., indicated Resident B walked over toward the nurse's desk and as he walked by Resident D, Resident B reached over and grabbed Resident D's hair with both hands and would not let go. It took two staff members to redirect him.</p> <p>A pain score evaluation, dated 6/8/25 at 2:35 p.m., indicated Resident D had a scratch on the back of her neck and had pain.</p> <p>A progress note, dated 6/10/25 at 11:15 a.m., indicated Resident B was walking across the dining room with the CNA that is assigned to provide one-on-one supervision for Resident B that shift. As Resident B passed by Resident D, he reached out and grabbed Resident D's arm with his left hand and then reached out with his right hand and grabbed Resident D's hair. Resident B would not let go of Resident D's hair. It took four people to redirect Resident B.</p> <p>2. The clinical record for Resident E was reviewed on 6/25/25 at 1:40 p.m. The diagnoses included, but were not limited to, muscular dystrophy, scoliosis, and myopia.</p> <p>A focused charting evaluation, dated 6/19/25 at 7:33 p.m., indicated Resident B had been physically aggressive toward Resident E. Resident E was seated in the main dining room and Resident B walked up and placed his hand on Resident E's face in what appeared to be an attempt to adjust Resident E's glasses.</p> <p>A skin evaluation, dated 6/19/25 at 7:34 p.m., indicated Resident E had a scratch below her right eye.</p> <p>During an interview on 6/26/25 at 9:58 a.m., CNA 1 indicated last week she was providing one-on-one supervision for Resident B. CNA 1 and Resident B were walking to the dining room and Resident E was sitting in her Broda chair. All of the sudden, Resident B reached over, opened his hand, and grabbed Resident E's face. It looked like Resident B was trying to grab Resident E's eyeballs but Resident E was wearing glasses. Resident E had a scratch and marks under where her glasses sat on her face. CNA 1 had witnessed Resident B be aggressive with multiple other residents. He likes eyeballs and sticking his fingers in other people's mouths.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. During an interview on 6/25/25 at 10:35 a.m., CNA 2 indicated on 6/20/25 she was providing one-on-one supervision for Resident B when Resident B walked into Resident F's room. Resident B put one of his thumbs into each of Resident F's eyes and pressed on Resident F's eyes. CNA 2 yelled for help and after approximately one to two minutes the staff were able to separate Resident B from Resident F and get Resident B out of the room. Resident F was sent to the hospital.</p> <p>During an interview on 6/25/25 at 10:47 a.m., LPN 1 indicated, on 6/20/25, she heard someone yell for help so she went to Resident F's room. Resident F's left eye had swelled and she could see a scratch under the left eye. Resident F was sent to the hospital and diagnosed with a corneal abrasion and had antibiotic eye drops.</p> <p>The clinical record for Resident F was reviewed on 6/25/25 at 1:35 p.m. The diagnoses included, but were not limited to, neurogenic bladder, aphasia, cerebral palsy, seizure disorder, and anxiety disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, 4/20/25, indicated Resident F was severely cognitively impaired, both upper and lower extremities were severely impaired, and was dependent for all activities of daily living.</p> <p>A progress note, dated 6/20/25 at 5:30 p.m., indicated Resident B went into Resident F's room and poked Resident F in the eye leaving a scratch. When CNA 2 attempted to redirect Resident B, he began open handed slapping Resident F in the face hitting Resident F in the eye and mouth causing swelling and redness to the left eye and causing bleeding in his mouth.</p> <p>A pain score evaluation, dated 6/20/25 at 5:33 p.m., indicated Resident F's left eye was red, swollen, and bruised with a scratch under the left eye. Resident F had pain.</p> <p>A progress note, dated 6/21/25 at 12:40 a.m., indicated Resident F returned from the emergency department with a new physicians order to instill one application of erythromycin ointment to left eye four times daily for a corneal abrasion.</p> <p>A current physicians order started, on 6/21/25 at 6:00 a.m., indicated erythromycin ophthalmic ointment 5 milligrams per gram, instill one application in left eye four times daily for corneal abrasion.</p> <p>On 6/25/25 at 9:00 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, dated 6/5/25, and indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to be free from abuse.</p> <p>This citation relates to Complaint IN00460596.</p> <p>3.1-27(a)(1)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received urinary incontinence care for a resident that was incontinent of urine for 1 of 3 residents reviewed for urinary incontinence. (Resident F)</p> <p>Findings include:</p> <p>On 6/25/25 from 10:59 a.m. until 11:07 a.m., observed Resident F sitting in the common area lying back in his wheelchair. There was a stream of urine running down from the wheelchair seat onto the floor where there was a large puddle of urine. Qualified Medication Aide (QMA) 1 walked up to Resident F's wheelchair and pushed it forward so the housekeeper could mop the floor. Once the housekeeper was finished mopping the area, he moved Resident F's wheelchair back. At that time, QMA 1 indicated she hadn't addressed Resident F's incontinence because the CNA's were busy and Resident F required a mechanical lift. LPN 1 was standing next to QMA 1 and QMA 1 indicated nurses were allowed to help provide incontinence care.</p> <p>The clinical record for Resident F was reviewed on 6/25/25 at 1:35 p.m. The diagnoses included, but were not limited to, neurogenic bladder, aphasia, cerebral palsy, seizure disorder, and anxiety disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 4/20/25, indicated Resident F was severely cognitively impaired, was impaired on both sides of upper and lower extremities, was dependent for activities of daily living, and was always incontinent of bladder.</p> <p>On 6/26/25 at 12:30 p.m., the facility was unable to provide a policy regarding incontinence care.</p> <p>3.1-41(a)(2)</p>		