STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Bedford	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 protect a resident's right to be free from mental abuse by staff for 1 of 3 residents reviewed for abuse. CNA's covered a resident's face with a pillowcase during care. This deficient practice would result in a reasonable person experiencing distress, disorientation, fear, and mental anguish. (Resident B, CNA 2, CNA 3) Finding includes:During an interview on 3/10/26 at 8:21 a.m., CNA 1 indicated staff should not have placed a pillowcase over Resident B's face. CNA 1 would have stopped the staff, removed the pillowcase from Resident B's face and made sure Resident B was okay, removed the staff from resident care areas, and reported what he saw to the Administrator as abuse. The clinical record for Resident B was reviewed on 3/10/26 at 8:50 a.m. The diagnoses included, but were not limited to, cerebral palsy, severe intellectual disability, and muscular dystrophy. During an interview on 3/10/26 at 9:53 a.m., the Social Service Director (SSD) indicated she walked into Resident B's room and saw CNA 2 and CNA 3 getting ready to transfer Resident B from his bed to his wheelchair. Resident B's head was not in the pillowcase, but Resident B's entire face was covered with a pillowcase. The SSD told CNA 2 and CNA 3 to stop what they were doing and remove the pillowcase from Resident B's face. CNA 2 removed the pillowcase and they finished the transfer. The SSD immediately reported what she saw to the Administrator and walked CNA 2 and CNA 3 to the office. CNA 2 indicated to the SSD that Resident B had spit at the staff and she didn't want to be spit on.An Investigation Statement, dated 2/11/26, indicated the SSD heard Resident B yelling so she went to check on him. The SSD saw a pillowcase cover Resident B's face. The pillowcase was removed from Resident B's face and the Administrator was notified immediately. The statement was initialed by the SSD.An Investigation Statement, dated 2/11/26, indicated CNA 4 witnessed a pillowcase over Resident B's face. An addendum to this statement, dated 2/16/26, indicated CNA 4 demonstrated to the Administrator how the pillowcase was placed on Resident B's face. CNA 4 draped a pillowcase from the top of her forehead to below the chin. On 3/10/26 at 9:10 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 6/2025, 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.This deficient practice was corrected on 2/13/26 after the facility implemented a systemic plan of correction that included the following actions: all staff was educated on the abuse policy, with ongoing monitoring and audits.This citation relates to Intake 2741973.410 IAC (Indiana Administrative Code) 16.2- 3.1-27(a)(1)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based in interview and record review, the facility failed to ensure staff possessed the skill sets to provide care to a resident with behavior health needs for 1 of 3 residents reviewed for behavioral health. (Resident B) Findings include:The clinical record for Resident B was reviewed on 3/10/26 at 8:50 a.m. The diagnoses included, but were not limited to, cerebral palsy, severe intellectual disability, and muscular dystrophy. A care plan, dated 11/4/25, indicated Resident B exhibited behavioral symptoms of hitting, kicking, and spitting at staff when providing care. The interventions included, but were not limited to, if Resident B becomes resistive to care or combative then postpone care and re-approach, initiated 11/4/24.During an interview on 3/10/26 at 9:53 a.m., the Social Service Director (SSD) indicated she walked into Resident B's room and saw CNA 2 and CNA 3 getting ready to transfer Resident B from his bed to his wheelchair. Resident B's head was not in the pillowcase, but Resident B's entire face was covered with a pillowcase. The SSD told CNA 2 and CNA 3 to stop what they were doing and remove the pillowcase from Resident B's face. CNA 2 removed the pillowcase and they finished the transfer. The SSD immediately reported what she saw to the Administrator and walked CNA 2 and CNA 3 to the office. CNA 2 indicated to the SSD that Resident B had spit at the staff and she didn't want to be spit on.During an interview on 3/10/26 at 12:12 p.m., the Director of Nursing (DON) indicated CNA 2 and CNA 3 had access to Resident B's cardex with the interventions that staff used to care for him. CNA 2 and CNA 3 should have known what interventions they could have used instead of covering Resident B's face with a pillowcase.On 3/10/26 at 11:50 a.m., the Administrator provided a copy of a facility policy, titled Behavior Management, dated 1/2/24, and indicated this was the current policy used by the facility. A review of the policy indicated it is the policy of the facility to provide all residents with a supportive environment aimed at relief of and/or accommodation of their behavioral needs in addition to person-centered interventions. This deficient practice was corrected on 2/13/26 after the facility implemented a systemic plan of correction that included the following actions: all staff were educated on behaviors, with ongoing monitoring and audits.This citation relates to Intake 2741973.