

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Majestic Care of New Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<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 resident's right to be free from physical abuse by staff for 1 of 3 resident's reviewed (Resident B). Findings include: On 4/1/26 at 12:50 P.M., Resident B's record was reviewed. Diagnoses included dementia. A quarterly Minimum Data Set (MDS) assessment, dated 1/15/26, indicated Resident B had moderately impaired cognition with no behaviors. He used a wheelchair for mobility, was able to propel himself short distances, but required moderate assistance for long distances. A care plan, dated 8/8/25, indicated Resident B had episodes of physical and verbal aggression towards others, trying to get their attention. He might hit, push, yell at, or antagonize others and block their way from getting past him in the hallway. Interventions included: approach the resident in a calm and friendly manner; explain to resident what you are doing prior to initiating a task; offer distraction or activity such as snack or watching a movie; remove him from the situation; and if he becomes combative or resistive, postpone care/activity, allow him to regain his composure and re-approach as needed. A nurse note, dated 3/12/2026 at 4:27 p.m., indicated Resident B was interviewed about an incident on 3/11/26. He could not recall anything out of the ordinary happening. He had no signs of psychosocial distress and continued with his normal day-to-day routine. A Nurse Practitioner (NP) note, dated 3/13/26 at an unknown time, indicated the resident was seen for exposure to wound cleanser. Resident B had allegedly been sprayed with wound cleanser to his face. He had no recollection of this and had no acute concerns. He had no breathing issues and his mentation remained at baseline. Review of a facility investigation, dated 3/12/26, indicated Housekeeper 1 had reported an incident to the Administrator. On 3/11/26, the staff member observed Resident B being sprayed with a liquid by Registered Nurse (RN) 4 while attempting to remove an item from his hands. On 4/1/26 at 1:15 P.M., Licensed Practical Nurse (LPN) 2 was interviewed. She indicated on 3/11/26, between 1:30-2:00 p.m., Resident B had been observed to take 2 packets of adhesive wipes off the counter of the nurse's station. LPN 2 asked for them back and the resident refused. She then offered him a snack in exchange for the packets, but he yelled at her and said No. RN 4, who was observing the exchange from behind the nurse station, came up to Resident B and sprayed something near his face causing him to drop the packets and look at RN 4. LPN 2 indicated RN 4 hadn't said a word to the resident, sprayed a wound cleanser near his face and then walked away. LPN 2 hadn't reported the incident because she hadn't thought of it as abuse. On 4/1/26 at 1:22 P.M., Housekeeper 1 was interviewed. She indicated she had been in the hallway in front of the nurse station and observed LPN 2 talking to Resident B who held something in his hands. LPN 2 was heard talking calmly to the resident, trying to coax the item from him but the resident refused and kept yelling at the nurse. She then observed RN 4 walk around the nurse station, approach the resident from behind and beside him and spray something towards his face. Resident B startled, looked at the nurse, and started wiping his face and rubbing his eye. RN 4 looked down the hall, saw the housekeeper looking at her and walked away. The housekeeper indicated initially, she hadn't thought it was considered abuse but felt uncomfortable with the incident. The following day, she reported it to her supervisor and the Administrator. On 4/1/26 at 1:52 P.M., the Administrator and Director of Nursing (DON) were interviewed. The DON indicated, as soon as the incident was reported (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>on 3/12/26, RN 4 was suspended pending investigation. LPN 2 and Housekeeper 1 were suspended for not reporting the incident immediately to the Administrator. The Administrator and DON reviewed video footage of the incident and investigation completed resulting in RN 4's termination of employment. A current facility policy, titled Abuse, was provided by the Administrator on 4/1/26 at 3:56 P.M. The policy indicated Residents had the right to be free from abuse defined as willful infliction of injury including disciplinary action taken for the purpose of penalizing or punishing a resident. Allegations of abuse were to be reported to the Administrator immediately and investigation started. The past non-compliance deficiency began on 3/11/26 and deficient practice corrected on 3/14/26 after the facility suspended the 2 employees for not reporting the abuse immediately, terminated employment of the employee involved in the incident, and reported to local law authorities and Indiana Department of Health as required. Resident B was observed for injury and monitored for psychosocial distress related to the incident. On 3/12/26, the facility took steps to identify other residents with the potential to be affected by completing interviews on all alert/oriented residents and performing skin assessments on all non-alert and oriented residents. There were no issues found. All staff were educated on the facility abuse and abuse reporting policies which were completed on 3/14/26. To ensure ongoing compliance, the facility would conduct 4 resident interviews and/or skin assessments weekly to assess for abuse and conduct 5 employee interviews weekly to ensure staff knew how to correctly report abuse for the next 6 months. This Citation relates to Intake 2803402. 410 IAC (Indiana Administrative Code) 16.2-3.1-27(a)</p>		