

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Majestic Care of South Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N Ironwood Rd South Bend, IN 46635	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident's physician and responsible party were notified of the resident's refusal to be weighed and of the resident's significant weight loss, for 1 of 3 resident's reviewed for weight loss, (Resident E). Finding includes: Resident E's clinical record was reviewed on 1/12/26 at 11:38 A.M. Resident E was admitted to the facility with diagnoses that included but were not limited to, Alzheimer's Disease, neurocognitive disorder with behavioral disturbance, delusional disorder, insomnia, and muscle weakness. The most recent comprehensive Minimum Data Set (MDS) assessment, completed for a quarterly review, dated 10/22/25, indicated Resident B had severe cognitive impairment, had demonstrated negative behaviors not directed toward others, wandered daily, and utilized antipsychotic and antianxiety medications. The resident's weight was 170 pounds at the time of the assessment. An MDS assessment, dated 11/26/25 for a Discharge Assessment, indicated the resident had inattention and disorganized thinking that was continuously present, had demonstrated physical and verbal behaviors directed toward others, behaviors not directed toward others, and rejection of care for 1 to 3 days in the previous 7 days of the assessment period. The resident's weight was 156lbs at the time of discharge. Physician's Orders for Resident B included, but were not limited to: a regular diet, regular texture, thin consistency, dated 7/23/25 and ongoing, and to obtain monthly weights, dated 7/23/25. Resident E's Care Plans included but were not limited to behavioral symptoms of refusing vital signs to be obtained, dated 10/13/25. Interventions indicated if the resident became resistive, to allow the resident to regain their composure and reapproach as needed and also to notify the physician and psychiatric services for increases in behavioral symptoms. A Care Plan dated 10/19/25 indicated Resident E had potential for nutritional risk related to her diagnoses and a weight refusal in October 2025 and in November 2025 was noted to have significant weight loss of 14.7 % in the previous 90 days. Interventions included to document food and fluid intake, dated 10/19/25, and to observe for difficulties, and notify the physician of abnormal findings, dated 7/23/25. Resident E's monthly weights were documented as follows: 7/24/25; 178.0 lbs 7/28/25; 177.0 lbs 8/5/25; 178.0 lbs 8/21/25; 171.0 lbs 9/2/25; 170.0 lbs 9/4/25; 170.0 lbs 11/6/25; 152.0 lbs, which indicated a 14% weight loss in less than 5 months, 11/11/25; 156.0 lbs. A local hospital emergency room (ER) History and Physical document dated 11/26/25, indicated Resident B was admitted to the ER due to an altered mental status, fever, and hypotension. The resident's weight was noted to be 146 pounds, which indicated a weight loss of over 17% in last five months. Review of Resident B's documented meal intakes from 10/1/25 to 11/26/25, indicated no meal intakes had been recorded for the following meals: No documentation of breakfast: 10/14/25, 10/19/25, 10/25/25, 10/26/25, 11/4/25, 11/11/25, 11/23/25, and 11/24/25. No documentation of lunch: 1/14/25, 10/19/25, 10/20/25, 10/25/25, 10/26/25, 11/4/25, 11/11/25, and 11/23/25. No documentation of supper: 10/4/25, 10/5/25, 10/14/25, 10/15/25, 11/4/25, 11/8/25, 11/12/25, 11/15/25, 11/21/25, and 11/22/25. Resident E's meal intake was documented as 0% intake to 25% on the following</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155219
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>dates: 10/5/25 breakfast and lunch, 10/7/25 breakfast, 10/8/25 breakfast and lunch, 10/22/25 breakfast, 10/24/25 lunch, 10/27/25 breakfast, 10/29/25 breakfast, 10/31/25 supper, 11/1/25 breakfast, 11/5/25 breakfast, 11/9/25 breakfast no lunch, 11/15/25 breakfast, 11/19/25 lunch, 11/20/25 breakfast.Nursing Progress Notes for Resident B included but were not limited to the following: On 8/1/25 at 6:25 A.M., a nutrition review indicated the resident had an admission weight of 178 pounds on 7/24/25 and consumed 76-100% of most meals. No dietary recommendations were made. On 11/21/25 at 1:33 P.M., a nutrition/dietary Note for weight review indicated Resident E was on a regular diet and was not prescribed any dietary supplements. The resident's weight history included weights of 156 lbs on 11/11/25 and 156 on 11/6/25. The note indicated no weights had been entered for 30 days and that the resident had lost 26 pounds in 90 days for a 14.6% weight loss, dropping from 170 pounds to 152 pounds in 2 months. The dietary note indicated the resident's Body Mass index (BMI) was 29.5 and in the overweight category. No recommendations due to a BMI of 29.5. were recommended The Registered Dietician indicated she would continue to monitor and follow up as needed. During an interview on 1/13/25 at 10:30 A.M., the Director of Nursing indicated there was no documentation of notification that Resident E's physician nor their responsible party had ever been notified of the resident's significant weight loss or weight refusals.During an interview, on 1/13/25 at 12:44 P.M. with Resident E's family member, they indicated the family was never notified of the resident's significant weight loss. On 1/14/25 at 9:00 A.M., the policy titled Weight Monitoring, dated 7/1/25, was provided by the Director of Nursing and indicated it was the current facility policy. The policy indicated, .To regularly measure and record a [resident's] body weight to assess changes in nutritional status.Monthly Weights; Should be taken by the 5th of the month with reweights verified and recorded in the [Electronic Medical Record].by the 7th of the month.The resident's.physician and family/guardian will be notified of any verified significant weight change.On 1/14/25 at 9:00 A.M., the policy titled Change in Condition/Physician Notification, dated 4/1/25, was provided by the Director of Nursing and indicated it was the current facility policy. The policy indicated, .Purpose [is to] promptly identify, respond to, and report changes in resident.condition to the resident's.physician.and representative.The nurse will notify the physician.and resident representative when.abnormal weights.The charge nurse will document timely regarding the change in resident's condition, intervention, and notifications.This citation relates to Intake 2698522 3.1-5(a)(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on interview, and record review, the facility failed to ensure foods were served under safe and sanitary conditions related to monitoring food temperatures before serving. This deficient practice had the potential to affect 69 of 70 residents who were served meals from the facility kitchen. Finding includes: On 1/7/25 at 10:45 A.M., facility Grievances from 10/1/25 to 1/7/25 were reviewed. On 12/16/25 the Resident Council had submitted a grievance that indicated Residents did not want their food served cold. A grievance, dated 12/20/25, indicated the food was served cold every day. A review of Resident Council Minutes, dated 11/18/25, indicated the residents had expressed concerns that breakfast was often cold when served to them and they wanted food to be served to them on time so that the food was hot when served. On 1/14/25, the Service Line Checklist logs from 12/1/25 to 1/14/26 were reviewed and indicated the following: 12/1/25: Breakfast temp recorded without items named. Lunch had no beverage items listed with the temps. Dinner had no beverage temps. 12/2/25: Breakfast temps recorded without items named. Lunch no fruit or dessert temp, no items listed. Dinner had no beverage temps. 12/3/25: Breakfast temps recorded without items named. Lunch had no alternate items listed, no dessert temps or item listed. Dinner had no beverage temps nor dessert item named or temp. 12/4/25: Breakfast temps recorded without items named. Lunch had no beverage temps no dessert temp or items listed. Dinner had no beverage temps. 12/5/25: Dinner had no beverage temps. 12/6/25: Breakfast temps recorded without items named. Lunch no fruit or dessert temp, no items listed. Dinner had no beverage temps. 12/7/25: Breakfast had no main entree temps. Lunch had no beverage temps and no main entree temp. Dinner had no beverage temps. 12/8/25: Breakfast had not main entree or breakfast meat temps. Lunch had no beverage temps. Dinner had not beverage temps. 12/9/25: Dinner had no beverage temps. 12/10/25: Breakfast temps recorded without items named. Lunch had no beverage temps. 12/11/25: Breakfast temps recorded without items named. Dinner had no beverage temps. 12/12/25: Breakfast temps recorded without items named. Dinner had no beverage temps. 12/13/25: Lunch had no beverage temps. Dinner had no temp checks. 12/14-16/25: Breakfast temps recorded without items named. Dinner had no beverage temps. 12/17/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps. 12/18/25: Breakfast temps recorded without items named. Dinner had no beverage temps. 12/19/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps and no dessert temp. 12/20/25: There were no beverage temps for this day. 12/21/25: No beverage temps for breakfast or lunch. 12/22/25: No beverage temps for lunch or dinner. 12/23/25: Breakfast temps recorded without items named. Dinner had no beverage temps. 12/24/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps and no dessert temp. 12/25/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps and no dessert temp. 12/26/25: 12/19/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps and no dessert temp. 12/27/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps. 12/28/25: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no beverage temps. 12/29/25: Breakfast had no main entree or meat temps. Lunch had no beverage temps. Dinner had no beverage temps. 12/30/25: Breakfast temps recorded without items named. Dinner had no beverage temps and no dessert temp. 12/31/25: Breakfast temps recorded without items named. Lunch had no food temps. Dinner had no beverage temps and no dessert temp. 1/1/26: Breakfast temps recorded without items named. Lunch temps recorded without items named. Dinner had no beverage temps. 1/2/26: Breakfast temps recorded without items named. Dinner had no beverage temps. 1/3/26: Breakfast temps recorded without items named. Lunch temps recorded without</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>items named and had no beverage temps. Dinner temps recorded without items named and had no beverage temps. 1/4/26: Breakfast temps recorded without items named. Lunch had no main entree temp, alternate entree, starch, or vegetable temps and had no beverage temps. Dinner had no beverage temps. 1/5/26: Breakfast temps recorded without items named. Dinner had no beverage temps. 1/6/26: Breakfast temps recorded without items named. Lunch had no beverage temps. Dinner had no temps for vegetables, alternate entree, or starch. 1/7/26: Breakfast temps recorded without items named. Lunch temps recorded without items named. Dinner had no beverage temps. 1/8/26: Lunch had no beverage temps. Dinner had no beverage temps. 1/9/26: Breakfast had no beverage temps. Lunch had no beverage temps. Dinner had no beverage temps. 1/10/26: Breakfast temps recorded without items named. Dinner had no beverage temps. 1/11/26: Breakfast temps recorded without items named. Lunch temps recorded without items named and had no beverage temps. Dinner had no beverage temps. 1/12/26: Dinner had no beverage temps. 1/13/26: Dinner had no beverage temps. 1/14/26: No Dinner temps were recorded. During an interview on 1/13/26 at 11:58 A.M., Resident D indicated the meals were frequently cold when served and the kitchen did not follow the posted menus. During an interview on 1/13/26 at 2:08 P.M., Resident G indicated the meals were not very good and the menu was not followed very closely. Resident G indicated they served biscuits and gravy way too often and that the hot food was never very hot. On 1/14/26 at 10:40 A.M., during an interview, Resident C indicated the kitchen did not always follow the menu and the hot food was not always hot. On 1/14/26 at 2:30 P.M., the Administrator indicated he was aware of the residents' concern for hot foods being served cold and that the posted menus were not closely followed. The Administrator indicated a new dietary manager was hired and began working at the facility on 1/12/26 and he had not received any food concerns since 1/12/26. On 1/14/25 at 9:00 A.M., the Director of nursing provided a policy titled Food Production, with a revised date of 10/6/25, and indicated it was the current facility policy. The policy indicated, .All food production within the facility shall follow safe food handling practices. All meats are heated through to a minimum temperature. a. 145? for fish, pork or beef roast, raw ham and bacon. b. 160? for eggs, ground beef and pork, ham, sausage. c. 165 ? for poultry, stuffed meats and stuffed pastas, and casseroles. This citation relates to Intake 2707368 and Intake 2695463.3.1-21(i)(3)</p>		