STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of South Bend	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)
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 interview and record review, the facility failed to notify a resident's representative of a medication change for 1 of 3 residents reviewed for resident rights. (Resident E)Finding includes:Resident E's clinical record was reviewed on 6/25/26 at 3:50 P.M. Diagnoses included, but were not limited to, restless leg syndrome, chronic pain, anxiety and hemiplegia following a stroke.A Minimum Data Set Quarterly Assessment, dated 6/9/26, indicated Resident E had moderate cognitive impairment.A review of the resident's POST (Indiana Physician Orders for Scope and Treatment) form, dated 10/10/25, indicated Resident E's legal representative was Family Member A.Resident E's Durable Power of Attorney form, dated 10/10/25, indicated the resident's Power of Attorney was Family Member A.The resident's physician orders included but were not limited to:Ropinirole Hydrochloride to give one -1 MG tablet by mouth one time a day related to restless legs syndrome, with a start date of 10/9/25 and an end date of 6/4/26.Ropinirole Hydrochloride to give 1 MG tablet, to give 1.5 tablet at bedtime related to restless legs syndrome, with a start date of 6/4/26 and no end date.Resident E's progress notes included, but were not limited to, a physician's note, dated 6/5/26 at 12:59 A.M., that indicated the chief reason for the visit with the resident was due to the resident's increased difficulties with restless legs and a request to increase the Ropinoril to see if the increase would help better control the symptoms. The note indicated the Ropinirole was increased from 1 mg daily to 1.5 mg at bedtime.A nursing progress note, dated 6/11/26 at 7:58 A.M., indicated Resident E's representative had been notified of the medication change. During an interview, on 6/26/26 at 9:52 A.M., the Director of Nursing indicated Resident E had a medication increase for restless legs syndrome on 6/4/26 and the resident's responsible party should have been notified of the medication change at the time of the change but had not been notified of the change until 6/11/26.On 6/26/26 at 11:04 A.M., the Director of Nursing provided the policy titled, Change in Condition/Physician Notification, dated 3/19/25 and indicated it was the current facility policy. The policy indicated, .Purpose To promptly identify, respond to, and report changes in Resident/Patient condition to the Resident's/Patient's physician/NP/PA and Resident/Patient and their representative.The nurse will notify.representative when [there is a].Need to alter medications or treatment.Notifications will be attempted withing 24 hours.This citation relates to Intake 3042643.410 IAC (Indiana Administrative Code) 16.2-3.1-5 (a)(3).

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