STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155247	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Southport	8549 S Madison Ave Indianapolis, IN 46227

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was prepared in a sanitary manner for 3 of 3 kitchen observations. Hair was not covered. (Dietary Aide 2) Finding includes: During an observation on 9/22/25 from 8:40 a.m. to 9:00 a.m., Dietary Aide 2 was observed in the kitchen's dishwashing area and food preparation area. Dietary Aide 2 was observed scooping dessert into small bowls for noon meal. Dietary Aide 2 was observed to be lacking hair coverage to the hair on her forehead measuring two inches in length. During an observation on 9/22/25 at 12:37 p.m., Dietary Aide 2 was observed placing food on plates to be served to the residents for the noon meal. Dietary Aide 2 was observed to be lacking hair coverage to the hair on her forehead measuring two inches in length. During an interview on 9/23/25 at 9:25 a.m., the Executive Director indicated that all staff in the kitchen should have all of their hair covered. During an interview on 9/24/25 at 2:58 p.m., the Executive Director indicated 79 of 83 residents received meals from the kitchen. On 9/23/25 at 9:25 a.m., the Executive Director provided a copy of Staff Attire from the Dining Services Policy and Procedure Manual, revised on 1/2025, and indicated it was the current policy in use by the facility. A review of the policy indicated, 1.All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained . On 9/26/24 at 2:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, (b)food employees shall wear hair restraints, such as hats, hair coverings or nets .that are designed and worn to effectively keep their hair from contacting .exposed food . 3.1-21(i)(2)3.1-21(i)(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

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician prescribed daily weights were taken and recorded by qualified personnel for 1 of 1 resident reviewed for daily weights. (Resident 74)Finding includes: On 9/24/25 at 2:33 p.m., Resident 74's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease (ESRD), dependence on renal dialysis, and heart failure. The admission Minimum Data Set (MDS) assessment, dated 9/1/25, indicated Resident 74 was cognitively intact.Physician orders included, but were not limited to, obtain daily weights, notify MD [medical doctor] if weight gain greater than 3 pounds in a day or 5 pounds in a week. The start date was 8/27/25 and no end date was indicated.On 9/25/25 at 10:50 a.m., the Director of Nursing Services (DNS) provided a copy of Resident 74's September 2025 Medication Administration Record (MAR). A review of the document indicated that nursing personnel had initialed the document which signified Resident 74's daily weights had been obtained from September 1st through the 24th. The document lacked a recorded numerical number of pounds for each date. During an interview at that time, the DNS indicated the MAR record lacked documentation that identified what the daily weights were. Staff had not recorded the weights on the MAR document.On 9/25/25 at 11:45 a.m., the DNS provided a copy of Resident 74's recorded weights for September of 2025. The record lacked recorded weights for the following dates: 9/4/25; 9/6/25; 9/11/25; 9/13/25; 9/14/25; 9/16/25; 9/18/25; 9/20/25; and 9/21/25. During an interview at that time, the DNS indicated there were nine days where no weights had been obtained or recorded for Resident 74. Resident 74's clinical record lacked documentation for daily weights as prescribed by the physician.During an interview on 9/25/25 at 2:30 p.m., Resident 74 indicated she had dialysis three times per week and was only weighed on her dialysis days.On 9/25/25 at 11:51 a.m., the DNS provided a copy of the Physician Orders policy, dated 1/2/24, and indicated it was the current policy in use by the facility. A review of the document indicated, .qualified nursing personnel will receive and review.communicate results to the ordering physician.documentation.will be maintained in the resident's clinical record.On 9/25/25 at 11:51 a.m., the DNS provided a copy of the Weight Monitoring policy, dated 6/15/25, and indicated it was the current policy in use by the facility. A review of the document indicated, .to regularly measure and record a resident's body weight to assess changes in nutritional status, fluid balance, and overall health status.Daily Weights: orders for daily weights should include physician call parameters indicating amount and timeframe of weight change.should be recorded on MAR or TAR [treatment administration record] should indicate if physician was notified or parameter change.3.1-35(g)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview the facility failed to document treatments that were completed in the residents clinical record for 1 of 3 residents reviewed for skin issues. (Resident B) Finding includes: On 9/26/25 10:37 a.m., the clinical record for Resident B was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and neuropathy. Physician orders, dated August 2025, indicated wound Care-left heel: Apply skin prep every morning and at bedtime. The Medication Administration Record lacked signatures that the treatment was completed on the following dates and times: - August 8, 2025, at bedtime. - August 9, 2025, in the morning. - August 10, 2025, at bedtime. - August 13, 2025, in the morning. - August 15, 2025, in the morning. - August 16, 2025, in the morning and at bedtime. - August 19, 2025, in the morning. During an interview on 9/26/25 at 10:00 a.m., the Director of Nursing Services indicated the treatments were completed. The treatments should have been documented in the resident's clinical record once the treatment was completed. On 9/26/25 at 11:21 a.m., the Executive Director provided a policy titled Documentation In The Medical Record, dated 12/12/23, and indicated it was the current policy being used by the facility. A review of the policy indicated Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation. This citation relates to Intake 2613003. 3.1-50(a)(1)