STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 8, 9, 10, 11, 12, and 15, 2023 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Census Bed Type: SNF/NF: 106 Total: 106 Census Payor Type: Medicare: 11 Medicaid: 79 Other: 16 Total: 106 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 18, 2023.	F 0000		
F 0572 SS=C Bldg. 00	483.10(g)(1)(16) Notice of Rights and Rules §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Phil Ford	Executive Director	06/12/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; Based on observation and interview, the facility failed to ensure resident rights were posted and readily accessible to 107 residents who resided in the facility. Findings include: During the Resident Council meeting on 05/11/23 at 2:14 P.M., the group indicated they were aware the resident rights were signed upon admission. They were unaware where the resident rights were posted in the facility. During an interview on 05/15/23 at 11:25 A.M., the Administrator indicated the resident rights could be found in each resident's admission packet but, he was unaware where the resident rights were posted in the facility. During a walk through of the facility on 05/12/23 at 11:26 A.M., the Administrator stopped by the admissions office, she was unaware where the resident rights were posted in the facility. He stopped by the Social Services office, she too was unaware of where the resident rights were posted in the facility. During an interview on 05/12/23 at 11:29 A.M., the	F 0572	F572 – Notice of Rights and Rules What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Three Resident Rights posters were order 5/15/23, during the Annual Survey process. All three were received and posted throughout the facility in Resident Common Areas on 5/19/23. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator indicated when the facility walls were painted, approximately two months ago, the resident rights were taken down and never placed back on the wall. They should be posted in a common area, where they are accessible to all residents. The facility didn't have a specific policy for the posting of resident rights, they followed regulations. 3.1-4(a)		deficient practice does not recur? 1. Residents were informed of the posting of the Resident Rights posters through Resident Council meeting on 5/25/23. 2. Resident Council President confirmed their posting during a tour with the facility ED. 3. Ongoing review by the ED and his designees will ensure placement of the postings and identify if at any time they need to be replaced. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the ED or designee, will review the placements in an ongoing manner. 2. Findings of these tours will be reported to the QA Committee monthly for 6 months and will continue until 100% compliance has been achieved.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the residents' choices. Based on record review, interview, and observation, the facility failed to complete Neurological Evaluations/Checks following falls for 3 of 22 residents reviewed for Quality of Care. (Residents 32, 22, and 69) Findings include: 1. The clinical record for Resident 32 was reviewed on 05/11/23 at 11:01 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, anxiety, depression, and COPD (Chronic Obstructive Pulmonary Disease). The resident received special treatments while in the facility that included, but was not limited to, oxygen therapy. The resident required extensive assistance of one staff member for transfers and toileting. The resident had two or more falls, with injuries that were not major, since the last assessment, a Significant Change assessment dated 12/19/22. An "Event Note", dated 02/18/23 at 9:49 A.M., was provided by the DON (Director of Nursing) on 05/15/23 at 8:30 A.M. The note indicated the resident was heard saying, "Help", from her room. The resident was found on the floor by the toilet. She was assessed for injuries and there was an abrasion found on her back. The resident was not wearing proper footwear. CNAs (Certified Nurse Aides) assisted her to the toilet. Neuro checks (neurological evaluations) were initiated. A "Neuro Check Assessment Form", dated 02/18/23 at 9:30 A.M., was provided by the ADON (Assistant Director of Nursing) on 05/11/23 at 3:08 P.M. The record indicated Neuro Checks were to	F 0684	**F684 Quality of Care** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 32 continues to reside at the facility and has experienced no negative outcome related to identified deficiency. 2. Resident 22 continues to reside at the facility and has experienced no negative outcome related to identified deficiency. 3. Resident 69 continues to reside at the facility and has experienced no negative outcome. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents with falls requiring neurological checks have the potential to be affected. 2. DNS or designee will educate all staff on Neurological checks/evaluation on/by 5/24/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS or designee will audit all neurological check forms to ensure assessment completion per the facility policy 3x/week x4 weeks, weekly x4 weeks, and then monthly x6 months. How the corrective action(s) will be	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be completed as follows: - every 15 minutes x (times) 1 hour, - every 30 minutes x 1 hour, - every hour x 4 hours, - every 4 hours x 24 hours, and - every shift until 72 hours. Assessments were completed at the following times: - 9:30 A.M., the time of the fall, - 9:45 A.M., - 10:00 A.M., - 10:15 A.M., 45 minutes after the fall, the record lacked an assessment at one hour after the fall, - 10:45 A.M., and - 11:15 A.M. No assessments were completed every hour for four hours per the assessment guidelines. The next assessment completed was at: - 3:15 ("1515" per the record) P.M., four hours later. 2. The clinical record for Resident 22 was reviewed on 05/11/23 at 10:44 A.M. An Admission MDS assessment, dated 04/03/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, hypokalemia, hypertension, and adult failure to thrive. The resident had falls prior to admission. A Progress Note, dated 04/04/23 at 1:27 P.M., indicated the staff had witnessed the resident sitting on the floor in front of her toilet. The resident had attempted to transfer herself from her wheelchair to the toilet and fell on her bottom. The vital signs and neurological checks were within normal limits. There were no injuries noted. The staff assisted the resident up and into her wheelchair. Education was provided to the		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/02/2023.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident to always ask for assistance. A Neuro Check Assessment Form, dated 04/04/23, indicated the resident was to have the following neuro checks: - every 15 minutes x 1 hour, - every 30 minutes x 1 hour, - every 1 hour x 4 hours, - every 4 hours x 24 hours, and - every shift until 72 hours. The Neuro Form for the resident, dated 04/04/23, indicated the following neuro checks were completed: - 12:15 P.M., - 12:30 P.M., - 12:45 P.M., and - 1:00 P.M., 45 minutes after the first neuro check. No other neuro checks were documented. During an interview on 05/11/23 at 1:15 P.M., QMA (Qualified Medication Aide) 2 indicated when a resident had a fall and neurological checks were started, they would complete them every fifteen minutes for the first hour, thirty minutes for an hour, every hour for four hours, and every four hours for 24 hours. The QMA could complete the vital signs and the nurse completed the assessment. 3. The clinical record for Resident 69 was reviewed on 05/12/23 at 2:16 P.M. A Significant Change MDS assessment, dated 01/28/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited, malignant neoplasm of the stomach, cancer, hypertension, diabetes, non-Alzheimer's disease,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dementia, anxiety, and depression. A Progress Note, dated 05/06/23 at 2:30 P.M., indicated the resident was found sitting on the floor in her room between the bed and the bedside table. The resident was trying to reach for the trash can and fell. A head-to-toe assessment was completed, and no injuries were observed. Neurological checks were initiated. A Neuro Check Assessment Form, dated 05/06/23, indicated the resident was to have the following neuro checks: - every 15 minutes x 1 hour, - every 30 minutes x 1 hour, - every 1 hour x 4 hours, - every 4 hours x 24 hours, and - every shift until 72 hours. The Neuro Form for the resident, dated 05/06/23, indicated the following neuro checks were completed: - 2:30 P.M., - 2:45 P.M., - 3:00 P.M., and - 3:15 P.M., 45 minutes after the first neuro check. No other neuro checks were completed. During an interview on 05/11/23 at 2:40 P.M., an Agency LPN (Licensed Practical Nurse) 3 indicated the nurse was to complete neurological checks on paper for 72 hours after a fall they would be given to medical records. The neuro checks were on paper and completed according to the guidelines at the top of the record form. They were every fifteen minutes for 1 hour, every thirty minutes for 1 hour, every hour for four hours,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	every four hours for 24 hours, and then every shift for 72 hours. 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent pressure ulcers that resulted in the development of Stage 3 pressure ulcers (Residents 16 and 103) and follow a physician's order (Resident 91) for 3 of 7 residents reviewed for pressure ulcers. Findings include: 1. During an observation of Resident 16's wound on 05/11/23 at 9:43 A.M., the Wound NP (Nurse Practitioner) cleansed the wound to the left heel. The area had slightly macerated skin. The wound bed was pink with no drainage. The wound measured 0.4 cm (centimeters) x (by) 0.4 cm. The Wound NP indicated she expected the wound to be macerated due to the treatment she had in	F 0686	**F686 Treatment Services to Prevent/Heal Pressure Ulcer** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 16 continues to reside at the facility. Preventative wound interventions in place. Treatment order in place for identified pressure wound and continues to be followed by Healing Partners. 2. Resident 103 no longer resides at the facility. Preventative wound interventions were in place prior to discharge. Treatment	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	place. The clinical record for Resident 16 was reviewed on 05/10/23 at 1:52 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/22/23, indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, Alzheimer's disease, hypertension, anxiety, depression, and contracture. The resident required total staff assistance with transfers, locomotion, eating, toileting, personal hygiene, and bathing. The resident had an unhealed Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss) pressure ulcer that was not present on admission. A Braden Scale for Predicting Pressure Sore Risk, dated 08/28/22, indicated the resident was a high risk for developing pressure ulcers. A Braden Scale for Predicting Pressure Sore Risk, dated 11/17/22, indicated the resident was a high risk for developing pressure ulcers. A Weekly Nursing Assessment, dated 11/23/22, indicated the resident had no current issues and the skin was warm and dry. The Shower Reports for the resident indicated the resident had no skin issues for the following dates: - 11/02/22, - 11/05/22, - 11/09/22, - 11/12/22, - 11/16/22,		orders were also in place for the identified pressure wound. Healing Partners rounded on resident weekly. 3. Resident 91 continues to reside at the facility. Facility staff collaborated with Our Hospice and received order to discontinue the pressure reducing boots due to resident refusal/kicking off. The resident has preventative measures in place. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents at risk for the development of wounds have the potential to be affected. 2. DNS or designee will educate all staff on Prevention of Pressure Injuries Policy and documentation of refusals on/by 5/24/23. 3. DNS or designee will review all Braden Scales to assess residents at risk for skin breakdown on/by 5/31/23. Residents who trigger a moderate to very high risk on the Braden Scale will have preventative interventions in place. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS or designee will review all new admission/readmission for Braden Scale risk and collaborate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 11/19/22, - 11/24/22, A Shower Report, dated 11/26/22, indicated the resident had open areas. A physician's order, dated 06/23/22 through 11/27/22, indicated the resident was to have skin prep to the left heel once a day for a preventative. A physician's order, dated 12/29/22 through 04/18/23, indicated the resident was to have Z-flow (off loading) boots, every shift, to the bilateral feet. The boots were to be removed for bathing and skin assessments. A Weekly Pressure Ulcer Observation, dated 11/28/22, indicated the resident had a Stage 3 pressure ulcer to the left heel, plantar surface, that was acquired in house. The pressure ulcer measured 3.4 cm x 2.4 cm x 0.1 cm. There was slough (yellow, tan, white, stringy) tissue present. The wound was moist and dry. There was a scant amount of serous (watery clear or slightly yellow/tan/pink fluid that has separated from the blood) drainage. A treatment was initiated. The facility indicated the wound was caused by the staff elevating the resident's leg rest on the Broda chair (a specialized wheelchair) due to edema of the left lower leg. Elevation of the leg rest had increased the pressure on the heels due to the resident's contractures. A Weekly Pressure Ulcer Observation, dated 12/29/22, indicated the resident had a Stage 3 pressure ulcer to the left heel. The pressure ulcer measured 3 cm x 4 cm x 0.1 cm. There was slough present with a moderate amount of serosanguineous drainage (drainage that contains blood and the liquid part of blood).		with NP/MD on preventative skin measures based on risk status 5x/week in daily clinical meeting. 2. DNS or designee will perform a second skin assessment within 24 hours of admission/readmission and document findings within the medical record x6 months. 3. DNS or designee will audit at risk residents for proper application of pressure reducing devices (if ordered) and preventative wound interventions 3x/week x4 weeks, weekly x4 weeks, and then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Weekly Pressure Ulcer Observation, dated 01/26/23, indicated the resident had a Stage 2 (partial thickness skin loss with exposed dermis) pressure ulcer to the left heel. The pressure ulcer measured 1.8 cm x 1.8 cm x 0.1 cm. The pressure ulcer was moist and had a small amount of serosanguineous drainage. A Weekly Pressure Ulcer Observation, dated 02/24/23, indicated the resident had a Stage 3 pressure ulcer to the left heel. The pressure ulcer measured 2.5 cm x 2.3 cm x 0.1 cm. The pressure ulcer had a moderate amount of serosanguineous drainage. A Weekly Pressure Ulcer Observation, dated 03/30/23, indicated the resident's Stage 3 pressure ulcer to the left heel was resolved. A Weekly Pressure Ulcer Observation, dated 04/13/23, indicated the resident had a Stage 3 pressure ulcer to the left heel that measured 2.3 cm x 3.2 cm. There was no drainage present. A Weekly Pressure Ulcer Observation, dated 05/04/23, indicated the resident had a Stage 3 pressure ulcer to the left heel that measured 0.8 cm x 0.6 cm x 0.2 cm. There was a scant amount of serosanguineous drainage. The progress notes lacked indication the resident had open areas to the left heel until the initial observation on 11/28/22. During an interview on 05/11/23 at 9:36 A.M., the Wound Nurse Practitioner indicated the resident's wound to the left heel had closed for about a week and it had opened again. The wound had always been a Stage 3. The resident had severe		**This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation. This provider alleges compliance as of 06/02/2023. The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contractures to the legs and had pressure no matter where her feet were placed. She always wore heel boots and had even tried a different boot recently, but it hadn't worked well so they had to switch back. During an interview on 05/11/23 at 1:39 P.M., the ADON (Assistant Director of Nursing) indicated at the time of the development of the pressure ulcer the resident was having increased swelling in her legs. She had contractures with no flexion, so when her legs were elevated on the footrest it made her left heel dig in more to the footrest even though she wore heel boots. It only took about a day and a half for it to develop. She felt that the footrest of the Broda chair was what caused the pressure. It was hard to float her heels in bed because they would dig in due to her body alignment. The nurses were to check the skin weekly, and the CNAs would check the skin when providing care and alert the nurse. The resident received showers or bed baths twice a week. The resident had received skin prep to the bilateral heels once a day until 11/27/22 and then it went to twice a day. On 11/23/22 the skin was intact. She would think that the staff would have noticed some skin impairment before the wound was a Stage 3. The resident had jerked a lot with tactile touch. She believed the staff probably were not inspecting the skin when they were applying the skin prep, they were probably just lifting the heel, wiping it on, letting it dry, and replacing the Z-flow boot. The area had healed in April, and she had switched the type of boot she was wearing to provide better relief, but it had the opposite effect and opened the wound back up. 2. During an observation on 05/11/23 at 11:04 A.M., Resident 103 was laying on her left side in bed. She was alerted that the staff were going to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	change her dressing to the coccyx. An old dressing was removed and dated 05/11/23. There was a moderate amount of purulent drainage. The wound was cleansed. The wound was covered in slough. The Wound Nurse Practitioner debrided the wound. There was tunneling present. The wound was packed with Dakin's (a bleach solution) soaked gauze and covered with a dressing. The wound measured 4.2 cm x 3.4 cm x 0.3 cm pre-debridement and was 6 cm x 7.2 cm x 1.2 cm with undermining from 10 o'clock to 3 o'clock at 5.5 cm, and 5 o'clock to 8 o'clock at 4.7 cm. During an interview on 05/11/23 at 10:54 A.M., the Wound Nurse Practitioner indicated the resident had started in March with blanchable redness to the coccyx. She had fallen and broken her hip. She mostly sat in her wheelchair or recliner and developed the pressure ulcer. She had seen her once week with the blanchable redness and then the next week it was unstageable. She was recently notified that the family had told the facility that she had an unstageable pressure ulcer to the same area that had healed prior to coming to the facility. The facility tried to culture the wound last week, but it was to dry. She had started the resident on an antibiotic for a potential wound infection. During an interview on 05/11/23 at 11:20 A.M., the Wound Nurse Practitioner indicated the wound was unstageable that day and had worsened. She had planned for it to be worse that week but not as bad as it was. There was bone palpable, and she was worried it would tunnel to the rectum, so she was going to request for a general surgery consult. An Admission MDS assessment, dated 03/27/23, indicated the resident was severely cognitively			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	impaired. The diagnoses included, but were not limited to, fractures, hypertension, non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The resident was frequently incontinent of bowel and bladder. She was at risk for skin impairments and required extensive assistance of two or more staff for bed mobility, transfers, toileting, and personal hygiene. A Braden Scale for Predicting Pressure Sore Risk, dated 03/21/23, indicated the resident was at risk for pressure sore development. A Skilled Care Nursing Documentation, dated 04/12/23, indicated the resident had no current skin issues. A Skilled Care Nursing Documentation, dated 04/13/23, indicated the resident had no current skin issues. The Shower Reports for April 2023 indicated the resident had no open areas on 04/04/23 and 04/07/23. The Shower Report, dated 04/12/23, indicated the resident had and open wound and house barrier cream was applied. The report was signed by the nurse. A Wound Assessment Report, dated 04/13/23, indicated the resident had a Stage 3 pressure ulcer to the coccyx that measured 4.2 cm x 4 cm x 0.1 cm. The wound had 50 to 74% slough (non-viable yellow/tan/gray/green/brown tissue, usually moist, stringy, mucinous in texture), with a moderate amount of serous drainage. A treatment was initiated.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Wound Assessment Report, dated 05/04/23, indicated the Resident had a Stage 3 pressure ulcer to the coccyx that measured 4.2 cm x 3.4 cm x 0.3 cm. There was 75 to 99% slough with a moderate amount of serosanguineous drainage. During an interview on 05/12/23 at 10:45 A.M., LPN 6 indicated the resident should have orders in the EMAR/ETAR for a wheelchair cushion or offloading mattress that the nurse would document was in place, each shift. The Complete Care Plan, was provided by the DON on 05/15/23 at 8:30 A.M., the Care Plan included, but was not limited to, the following: - The resident was at risk for skin breakdown with a start date on 03/15/23 and a revision date of 04/03/23. The interventions included, to assist the resident with bed mobility to turn and reposition routinely, assist with routine toileting, check for incontinence, and provide incontinent care as needed. Notify the nurse of any redness or irritation, preventative skin care as ordered/indicated, skin inspection weekly and as needed, document and notify the MD of abnormal findings. The interventions were all initiated on 03/15/23. During an interview on 05/11/23 at 1:21 P.M., QMA 2 indicated the resident was admitted to the facility and then fell shortly after coming and broke her hip. Ever since the fall she had a decline in her health. She coccyx wound had gotten worse. The wound had started as a red area and then opened. The resident had a cushion in the wheelchair and the nursing staff would move it to the recliner when she wanted to sit in the recliner as she had not been in her bed a lot. She recently had an air mattress in place. She would alert the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Unit Manager of any redness and they would document in a progress note. During an interview on 05/11/23 at 1:52 P.M., the ADON indicated the resident had not had very good nutrition. She believed the resident developed the area to her coccyx from pressure. The resident was thin. When she fell and broke her hip she liked to sit up in the den in her wheelchair or the recliner. She would grip the table and rock back and forth and cause friction on her coccyx. It didn't take long for the pressure to settle in. The resident had a cushion to the recliner and wheelchair. During an interview on 05/12/23 at 10:24 A.M., the ADON indicated she was told about the blanchable redness but had never documented it. The staff should have documented the blanchable redness on the skilled nursing assessments or shower sheets. During an interview on 05/12/23 at 10:36 A.M., CNA 11 indicated she would look for redness or open areas on residents skin while giving showers or daily care. She would alert the nurse of any redness or new open areas. During an interview on 05/12/23 at 1:35 P.M., the ADON indicated pressure reducing mattress and cushions were documented on the EMAR/ETAR. Every mattress in the building was offloading and every resident was issued a cushion when admitted to the facility. She didn't agree with the Wound Nurse Practitioners assessments that it was a Stage 3 when it was found. The current undated, facility policy titled, "Prevention of Pressure Injuries", was provided by the DON on 05/15/23 at 8:30 A.M. The policy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "...The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors...During skin assessment inspect presence of erythema, temperature of skin and soft tissue, and edema...Inspect the skin on a daily basis when performing or assisting with personal care of ADL's [Activities of Daily Living]. Identify any signs of developing pressure injuries...Evaluate, report and document potential changes in the skin...review the interventions and strategies for effectiveness on an ongoing basis..." 3. Resident 91 was observed in his room on 05/09/23 at 1:56 P.M. The resident was in bed, under the covers. The resident was not wearing pressure reducing boots. On 05/11/23 at 10:37 A.M., the resident had moved to a different room. The resident was in bed and appeared to be sleeping. The head of the bed was elevated, and the resident was wearing non-skid socks with his heels resting on the mattress. The resident's pressure reducing boots were observed on a dresser against the wall. On 05/11/23 at 1:20 P.M., the resident was observed in his room in bed. The resident's heels were not floated, and the boots were in same place on the dresser. On 05/12/23 at 10:22 A.M., the resident was observed in his room in bed. The resident was wearing non-skid socks. The resident's heels were resting on the mattress. The pressure reducing boots were sitting on the dresser. The resident indicated the last time he wore the boots was a few weeks ago. A CNA (Certified Nurse Aide) entered the room and asked the resident if he needed anything. The CNA did not reposition the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's heels to ensure they were not touching the mattress, nor did she offer to apply the pressure reducing boots to the resident's feet. On 05/15/23 at 10:37 A.M., the resident was observed in bed. The resident had pillows under his legs, but his legs were bent in such a way that that resident's heels were resting on the mattress. The pressure reducing boots were in the closet on top of a folded blanket. The resident's clinical record was reviewed on 05/15/23 at 11:19 AM. A Quarterly MDS assessment, dated 01/20/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, stroke, hemiplegia affecting the left side, seizure disorder, and malnutrition. The resident received hospice services. The resident was at risk for pressure ulcers and utilized pressure reducing devices for the bed and chair. During an interview on 05/15/23 at 10:38 A.M., LPN 6 indicated the resident had no pressure ulcers at that time. He had pressure reducing boots and he usually wore them. Sometimes when he wore them, he might say his feet were "stuck", but he was tall, so they usually would just need to pull him up in bed to reposition him so his feet wouldn't touch the end of the bed frame or the wall. The nurses signed off that the boots were in place every shift on the EMAR. If the resident refused to wear the boots it should be documented on the EMAR and in a Progress Note. The May 2023 EMAR was provided by the DON on 05/15/23 at 12:25 P.M. An open-ended physician's order, with a start date of 07/11/22, indicated the resident was to wear heel boots			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	every shift as a preventative measure. The EMAR documentation indicated the boots were applied every day and night shift. A Care Plan, initiated on 04/15/2022, indicated the resident was at risk for skin breakdown. Interventions included, but were not limited to, bilateral heel protectors applied as a preventative measure, with a start date of 07/20/22. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement Care Plan interventions for 1 of 5 residents reviewed for falls in the facility. (Resident 32) Findings included: The clinical record for Resident 32 was reviewed on 05/11/23 at 11:01 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, anxiety, depression, and (COPD) Chronic Obstructive Pulmonary Disease). The resident required extensive assistance of one staff member for transfers and toileting. The	F 0689	**F689 Free of Accidents/Hazards/Supervision/ Devices** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 32 continues to reside at the facility. Bright colored tape was placed on resident call light at the time of identification. How other residents having the potential to be affected by the same deficient practice will be identified and what correction	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had two or more falls, with injuries that were not major, since the last assessment, a Significant Change assessment dated 12/19/22. An IDT (Interdisciplinary Team) note, dated 12/12/22 at 10:03 A.M., was provided by the DON (Director of Nursing) on 05/15/23 at 8:30 A.M. The note indicated the resident had an unwitnessed fall on 12/09/22 at 5:42 A.M., in her room. The resident complained of left wrist pain and the wrist was swollen. The new intervention listed in the note was to put bright colored tape to the resident's call light. Event Notes, dated 02/18/23 and 02/20/23, indicated the resident had unwitnessed falls in her room. The Risk for Falls Care Plan was provided by the DON on 05/15/23 at 8:30 A.M. Interventions included, but were not limited to: Brightly colored tape on call light with an initiated date of 12/09/22. During an observation on 05/11/23 at 9:16 A.M., the resident was in her room sitting in her wheelchair. Her call light was laying on her bed within reach. The call light lacked brightly colored tape. During an observation on 05/12/23 at 2:17 P.M., with QMA (Qualified Medication Aide) 9, the resident was lying in bed, her call light was clipped to a blanket on her bed. No brightly colored tape was on the call light to assist the resident. During an interview on 05/12/23 at 2:41 P.M., with QMA 9 indicated she knew what Care Plan interventions were in place for the residents by looking at their Kardex (brief overview of the resident) Report. Looking at the Kardex on the computer, it indicated the resident was to have		action(s) will be taken? 1. All Residents with falls have the potential to be affected. 2. DNS or designee will educate all staff on Fall Management Policy on/by 5/24/23. 3. All fall care plans will be distributed to facility Magic Makers by the MDS coordinator on/by 5/31/23 to ensure all fall care plan interventions are in place. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS or designee will audit all new fall care plan interventions to ensure they are in place 3x/week x4 weeks, weekly x4 weeks, and then monthly x6 months. 2. Designated Magic Makers will audit rooms and interventions 3x/week x4 weeks, weekly x4 weeks, and then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	brightly colored tape on her call light. The QMA indicated she had not seen brightly colored tape on the resident's call light when we observed it earlier. The current "Visual/Bedside Kardex (brief overview of the resident) Report, dated "As of 05/12/23", was provided by QMA 9 on 05/12/23 at 2:46 P.M. The report indicated, under "Resident Care", "Brightly colored tape on call light." The current Fall Management policy, with a revised date of January 2023, was provided by the DON on 05/15/23 at 10:55 A.M. The policy indicated, "...The resident specific care requirements will be communicated to the assigned care team member utilizing the Kardex..." 3.1-45(a)(2)		2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/02/2023.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to administer oxygen as	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning**	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ordered by the physician for 1 of 2 residents reviewed for Respiratory Care. (Resident 32) Findings include: During an observation on 05/08/23 at 11:50 A.M., CNA (Certified Nurse Aide) 8 brought Resident 32 out of the bathroom in her wheelchair. The resident was not wearing oxygen. The CNA turned on the oxygen concentrator machine sitting at the side of the resident's bed and assisted the resident with her oxygen tubing. The tubing was rolled up in a plastic bag hanging on her machine. The CNA placed the nasal cannula appropriately under the resident's nose. The oxygen was observed to be set on 2.5 liters per minute. During an observation on 05/10/23 at 11:23 A.M., the resident's oxygen concentrator was set at 2.5 liters per minute. The resident was lying in bed wearing her oxygen nasal cannula. During an observation and interview on 05/12/23 at 9:53 A.M., with the Weekend Nursing Supervisor, the resident's oxygen concentrator was running at 2 liters per minute. The nasal cannula and tubing were coiled and lying on top of the machine. The Supervisor indicated the resident took her oxygen off and propelled herself down the hall. The resident was on 2 liters of oxygen per minute. Staff checked her oxygen levels with a pulse oximeter at least once a shift. During an observation on 05/12/23 at 2:15 P.M., the resident was in her room in bed wearing oxygen at 2 liters per minute per nasal cannula. The clinical record for Resident 32 was reviewed on 05/11/23 at 11:01 A.M. A Quarterly MDS		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 32 continues to reside at the facility. Resident experienced no negative outcomes related to identified deficiency. Oxygen order was changed to PRN per the physician orders on 5/10/23. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents with routine oxygen orders have the potential to be affected. 2. DNS or designee will educate all staff on Oxygen Administration Policy on/by 5/24/23. 3. DNS or designee will review all routine oxygen orders to ensure orders match liter flow being administered on/by 5/31/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS or designee will audit all routine oxygen orders to ensure correct physician ordered liter flow is being administered 3x/week x4 weeks, weekly x4 weeks, and then monthly x6 months. How the corrective action(s) will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Minimum Data Set) assessment, dated 03/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, anxiety, depression, and COPD (Chronic Obstructive Pulmonary Disease). The resident received special treatments while in the facility that included, but were not limited to, oxygen therapy. The EMAR/ETAR (Electronic Medication Administration Record/Treatment Administration Record) for May 2023, was provided by the DON (Director of Nursing) on 05/15/23 at 10:55 A.M., and included, but was not limited to, the following physician's orders: - Oxygen at 1 liter via nasal cannula, every shift for oxygen therapy, with a start date of 08/16/22, and a discontinued date of 05/10/23 at 9:04 A.M., and - Oxygen at 1 liter via nasal cannula, as needed for shortness of breath/dyspnea, with a start date of 05/10/23 at 9:15 A.M. During an interview on 05/12/23 at 2:41 P.M., with QMA (Qualified Medication Aide) 9 indicated she knew what Care Plan interventions were in place for the residents by looking at their Kardex (brief overview of the resident) Report. The current "Visual/Bedside Kardex Report", dated "As of 05/12/23", was provided by QMA 9 on 05/12/23 at 2:46 P.M. The report indicated, under "Resident Care", "OXYGEN as ordered". A Care Plan indicating the resident was at risk for respiratory distress related to COPD was provided by the DON on 05/15/23 at 10:55 A.M. The interventions included, but were not limited to,		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/02/2023.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"OXYGEN as ordered" with an initiated date of 03/23/23. The current "Oxygen Administration" policy, with a copyright date of 2022, was provided by the DON on 05/15/23 at 10:55 A.M. The policy indicated, "...Oxygen is administered under orders of a physician...Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment..." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to appropriately follow the physician's orders related to once a day medication administration for 1 of 6 residents reviewed for pharmacy services. (Resident 98) Findings include: Resident 98 was observed in her room on 05/10/23 at 11:26 A.M. The resident indicated she had been experiencing stomach issues for the last few months. She had some pain, but mostly she was just nauseated all the time. The NP (Nurse Practitioner) adjusted some of her medications and started her on some new medications. She was supposed to have a consult with a specialist soon. She felt like she was taking too many pills for her stomach. The resident's clinical record was reviewed on 05/12/23 at 1:21 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/15/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, major depressive disorder, hypertension, diabetes, quadriplegia, depression, and schizophrenia. A physician's order, dated 03/01/23, indicated the resident was to receive omeprazole (a medication used to treat GERD [gastroesophageal reflux disease], heartburn, and ulcers), 40 mg (milligrams)	F 0755	**F755 Pharmacy Services/Procedures/Pharmacist/Records** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 98 continues to reside at the facility. Resident experienced no negative outcomes related to identified deficiency. 2. Duplicate Omeprazole order was discontinued at the time of identification and the facility MD was notified with no new orders. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents have the potential to be affected. 2. DNS or designee will educate all staff on Medication Errors Policy on/by 5/24/23. 3. Pharmacy consultant will review all resident current orders to ensure no duplicate medication orders on/by 5/31/23. What measures will be put into place and what systemic changes	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	every day. The March, April, and May 2023 EMARs (Electronic Medication Administration Records) were provided by the DON (Director of Nursing) on 05/11/23 at 3:34 P.M. The EMARs included the following medication orders: - An open ended physician's order, with a start date of 03/04/23, to administer a 40 mg omeprazole delayed release capsule one time a day at 5:00 A.M. for GERD and, - An open ended physician's order, with a start date of 03/02/23, to administer a 40 mg omeprazole delayed release capsule one time a day at 6:00 A.M. for GERD. The medication was signed off as administered every day at 5:00 A.M. by a night shift nurse and at 6:00 A.M. by a day shift nurse. During an interview on 05/11/23 at 3:24 P.M., the DON indicated it looked like the resident was getting the medication twice a day. The resident shouldn't be getting the medication twice. The resident's pharmacy recommendations for April 2023 were reviewed on 05/12/23 at 2:05 P.M. The resident's medications were reviewed by the pharmacy consultant, and there were no recommendations related to the duplicate orders for the omeprazole medication. The current, undated facility policy, titled "Medication Errors" was provided by the Administrator on 05/15/23 at 2:22 P.M. The policy indicated, "...It is the policy of the facility to provide protections for health, welfare, and rights of each resident...The facility shall ensure		will be made to ensure that the deficient practice does not recur? 1. DNS or designee will audit all new admission orders to ensure no duplication during transcription has occurred 3x/week x4 weeks, weekly x4 weeks, and then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/02/2023.** **The facility respectfully**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications will be administered...according to physician's orders..." 3.1-25(a)		**requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medication appropriately for 3 of 4 medications carts and 1 of 1 medication rooms observed. (A-Hall, B-Hall, and D-Hall medication carts and the facility medication room)	F 0761	**F761 Label/Store Drugs and Biologicals** What corrective action(s) will be accomplished for those residents found to have been affected by the	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. During an observation and interview on 05/15/23 at 11:41 A.M., the B-Hall Medication Cart was observed with QMA (Qualified Medication Aide) 2. The cart contained an undated bottle of Lantus (an insulin medication) that was full. The medication bag indicated the medication was dispensed on 05/11/23. The QMA indicated the resident was newly admitted to the facility and already had an opened bottle of the Lantus in the medication cart that was opened on 05/12/23. The medication should have been put in the refrigerator until it was ready to be used. The resident received 25 units at bedtime. 2. During an observation on 05/15/23 at 11:44 A.M., the D-Hall Medication Cart was observed with RN 12 the cart contained the following: - a bottle of Humalog (an insulin medication) for Resident 56 was almost full, with an open date of 04/12/23, and - a bottle of Novolog (an insulin medication) for Resident 50 that was half full with an open date of 04/13/23. The RN indicated the medications were good for 28 days after they were opened and should have been discarded. The "Humalog" insert was provided by the DON on 05/15/23 at 12:30 P.M. The insert indicated "...Humalog vials should be stored at room temperature...and must be used within 28 days or be discarded, even if they still contain Humalog..." The "Novolog" insert was provided by the DON on 05/15/23 at 12:30 P.M. The insert indicated,		deficient practice? 1. The B Hall medication cart contained an undated vial of Lantus that was full during the observation period. The medication was discarded of following policy. The resident had an already opened vial of Lantus available at time of observation. The resident did not experience any negative outcome related to the identified deficiency. 2. The D Hall medication cart contained one vial of Humalog with an open date of 4/12/23 (Resident 56) and one vial of Novolog with an open date of 4/13/23 (Resident 50) during the observation period. The medications were discarded of following policy. The medications were both reordered from the pharmacy. The residents did not have any negative outcome related to the identified deficiency. 3. The A Hall medication cart contained one vial of Insulin Lispro with an open date of 4/14/23 (Resident 44) during the observation period. The medication was discarded of following policy. The medication was reordered from the pharmacy. The resident did not have any negative outcome related to the identified deficiency. 4. The Medication Room located on C Hall contained a bottle of Nystatin mouth wash with no open date and medication was no longer utilized by Resident 11; a bottle of liquid Omeprazole with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Vials: After initial use a vial may be kept at temperature below 86 degrees for up to 28 days..." 3. During an observation on 05/15/23 at 11:53 A.M., the A-Hall Medication Cart was observed with LPN (Licensed Practical Nurse) 6. The cart contained a bottle of insulin lispro for Resident 44. The insulin had an opened date of 04/14/23 that was half full. An "Insulin Lispro" insert was provided by the DON on 05/15/23 at 12:30 P.M. The insert indicated, "...In-use Insulin Lispro Injection vials...should be stored at room temperature...and must be used within 28 days or be discarded..." 4. The facility medication room was observed on 05/15/23 at 11:59 A.M. with RN 12. The refrigerator contained the following: - a bottle of nystatin mouth wash for Resident 11 with no open dated, the RN indicated the medication was no longer used and should have been discarded, - a bottle of liquid omeprazole that was 3/4 full for Resident (1), the bottle had an open date of 07/09/22 and expired date of 08/09/22. A plastic bag the medication was in had a dispense date of 04/13/23 and expire date of 05/14/23. The RN indicated she was unsure why all the dates were different, and -an opened bottle of liquid gabapentin that contained 300 ml (milliliters), 1/2 full, for Resident (1) with no open date. The current undated, facility policy titled, "Medication Storage" was provided by the DON (Director of Nursing) on 05/15/23 at 12:30 P.M. The policy indicated, "...It is the policy of this facility to ensure all medications housed on our		an open date of 7/9/22 and expiration date of 8/9/22 (Resident 1); and an opened bottle of liquid Gabapentin with no open date (Resident 1) were found during the observation period. The medications were discarded of following policy. The medications Omeprazole and Gabapentin were reordered from the pharmacy. The residents did not have any negative outcomes related to the identified deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents have the potential to be affected. 2. DNS or designee will educate all staff on Medication Administration and Storage of Medication Requiring Refrigeration Policy on/by 5/24/23. 3. DNS or designee will conduct a medication cart audit on each hall to ensure medications are labeled, not expired, and stored appropriately on/by 6/1/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS or designee will audit all medication carts to ensure medications are labeled, not expired, and stored appropriately 3x/week x4 weeks, weekly x4 weeks, and then monthly x6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security... The current facility policy titled, "Expiration Dating", with a review date of 01/05/2018, was provided by the DON on 05/15/23 at 2:23 P.M. The policy indicated, "...To ensure all prescription drugs/medication(s) are labeled with appropriate expiration dates according to manufacturer recommendations and in compliance with State and Federal regulations and that all expired drugs/medication(s) are removed from medication storage areas for proper disposal..." 3.1-25(a)		months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or Designee will review any findings five days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/02/2023.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0812 SS=D	483.60(i)(1)(2) Food			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to maintain residents' snack refrigerators related to unlabeled items, outdated items, and the storage of non-resident food items for 2 of 3 resident snack refrigerators reviewed. (Dementia unit and C-Hall snack refrigerators) Findings include: 1. The nourishment area on the Dementia unit was observed with QMA (Qualified Medication Aide) 2 on 05/15/23 at 10:13 A.M. The snack refrigerator contained the following: - A nearly empty two-liter bottle of soda. QMA 2 indicated it belonged to a resident. There was no label that indicated which resident it belonged to,	F 0812	F812 Food Storage What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. The items that were not properly labeled for Residents were removed from the snack refrigerators and discarded. 2. The items that were not dated properly and/or have expired were removed from the snack refrigerators and discarded. How other residents having the potential to be affected by the	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- A less than half full clear pitcher of orange juice dated 05/08/23, - A less than a quarter full clear pitcher of reddish purple colored juice dated 05/08/23, - A half full clear pitcher of orange drink dated 05/11/23, and - A plastic grocery bag in the freezer that contained brine shrimp fish food for the fish tank. During an interview on 05/15/23 at 10:13 A.M., QMA 2 indicated resident items brought in from home should be labeled. The drinks were good for 3 days after the date on the pitchers, and the fish food shouldn't be stored in the resident refrigerator. 2. The nourishment room on C-Hall was observed with QMA 4 on 05/15/23 at 10:15 A.M. The snack refrigerator contained the following: - An unlabeled, 3/4 full container of a cheesecake dessert, with a store label that indicated use by 05/14/23, - A 1/2 full, unlabeled open bag of green grapes, - A nearly empty gallon container of orange juice, with a sell by date of 05/06/23, - A plastic grocery bag that contained a larger bag of string cheese. There was no label that indicated which resident it belonged to, and - A plastic grocery bag in the freezer that contained hot cheese puffs, a water bottle, candy, and a granola bar.		same practice will be identified and what corrective action(s) will be taken? All snack refrigerators have been inspected throughout the facility. No other incorrect items were identified from that inspection. No further corrective action was needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Staff inservices have been performed providing education on what should be stored in the snack refrigerators and the requirements for the proper labeling and dating of those Resident items. 2. Ongoing review by the DNS or her designee will be performed to ensure the snack refrigerators contain on the appropriate items that are properly labeled and dated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or her designee, will inspect the snack refrigerators throughout the facility 5 days a week for 2 weeks, then weekly for 6 months. 2. Findings will be reported at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 05/15/23 at 10:15 A.M., QMA 4 indicated she thought the items in the freezer belonged to a staff member. Food that belonged to residents should be labeled. Expired items should be thrown away. Staff shouldn't store their things in the residents' refrigerator. The current facility policy, titled "Foods Brought by Family/Visitors", with a revision date of October 2017, was provided on 05/08/23 at the entrance conference. The policy indicated, "...Food brought in by family/visitors that is left with the resident to consume later will be labeled...nursing staff will discard perishable foods on or before the "use by" date..." The current facility policy, titled "Refrigerators and Freezers", with a revision date of December 2014, was provided by the Administrator on 05/15/23 at 2:22 P.M. The policy indicated, "...All food shall be appropriately dated to ensure proper rotation by expiration dates...Supervisors will be responsible for ensuring food items in...refrigerators and freezers are not expired or past perish dates..." 3.1-21(i)(3)		the QA Meeting for 6 months and will continue until 100% compliance has been achieved.	
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.			
	Based on record review and interview, the facility failed to demonstrate that ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers, that were previously cited on the last annual survey, for 4 of 7 residents reviewed for pressure ulcers. Findings include:	F 0867	F867 QAPI / QAA Improvement Activites What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Specific corrective actions for the Residents affected by this	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The current facility policy, titled "Quality Assessment and Performance Improvement (QAPI) Plan", with a revised date of 10/03/17, was provided by the Administrator following the Entrance Conference on 05/08/23. The policy indicated, "...This facility shall develop, implement, and maintain an ongoing, effective, comprehensive, facility-wide...QAPI...Program that focuses on indicators of the outcomes of care and quality of life...The Plan covers all systems of care...including...clinical care..." During this annual Recertification survey, from 05/08/23 to 05/15/23, one deficiency was a repeated citation from the last annual survey, F686. The facility's Quality Assurance Committee did not implement on-going appropriate measures to correct identified issues or prevent deficiencies as follows: 1. Pressure Ulcers: Three residents acquired pressure ulcer wounds that the facility failed to identify and prevent. Cross reference F686 During an interview on 05/15/23 at 1:49 P.M., the Administrator indicated during the QAPI process, after data was presented, they determined if they would make an action plan. Over the last three months they had been looking at falls with injuries and at antipsychotic medications related to GDRs (Gradual Dose Reductions). He thought there was a QAPI on pressure ulcers before he came to the facility in October 2022. They had added Healing Partners (subcontractors) to assist in wound management. Things were being found and being		deficient practice are being address in the Plan of Correction under F686 – Please cross reference F686 2. During the interview on 5/15/23 at 1:49 pm, the ED's complete statement was 'Since coming to the facility in October, QAPI action plans had been in place addressing pressure ulcers and as a result of these action plans an intervention of contracting Healing Partners had been put into place to add expertise to our Wound Care efforts. Since these changes, improvement had been noted.' How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? 1. Please cross reference F686 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. The facility's QAPI data collection and analysis systems, specifically but not solely, related to pressure ulcers, has been reviewed for improved methods and approaches to apply stronger focus on improving Resident condition. 2. The facility's Medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	found more quickly. During the exit conference on 05/15/23 at 2:27 P.M., no further documentation or QAPI audits related to pressure ulcers were provided by the facility for review. 3.1-52(b)(2)		Director is fully involved in this process offering guidance where appropriate. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the ED or designee, will review this process in an ongoing manner continuously seeking improvement. 2. Findings will be reported at the QA meeting for 6 months and will continue until 100% compliance has been achieved.	