PRINTED: 10/13/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. Building <u>00</u>			ETED	
		155665	B. W	ING		09/21	/2022
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					ENRY STREET		
MAJES	TIC CARE OF NORT	TH VERNON		NORT	H VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
F 0000							
Bldg. 00							
	This visit was for the	he Investigation of Complaints	F 0	000	Respectfully request a desk		
		390208, and IN00389984 .		300	review.		
	11 (000) 0000, 11 (000	1100390000, 1100390200, and 1100389984.			Toviow.		
	Complaint IIN0039	90086 - Unsubstantiated due to					
	lack of evidence.	o o o o o o o o o o o o o o o o o o o					
	nack of evidence.						
	Complaint IN0039	0208 - Substantiated.					
	*	iency related to the allegation is					
	cited at F584.	iency related to the anegation is					
	ched at 1 364.						
	Commissint IN10029	20094 Substantiated No.					
	_	19984 - Substantiated. No					
	deficiencies related	to the allegatioon is cited.					
	C 1-4 C4-						
	Survey dates: Septe	ember 20 and 21, 2022					
	F '11'4 1 01	10007					
	Facility number: 01 Provider number: 1						
	AIM number: 2002	232210					
	G D 1 T						
	Census Bed Type:						
	SNF/NF: 108						
	Total: 108						
	Census Payor Type	<b>::</b>					
	Medicare: 11						
	Medicaid: 92						
	Other: 5						
	Total: 108						
		a . a . <del> </del>					
		reflect State Findings cited in					
	accordance with 41	0 IAC 16.2-3.1.					
	Quality review com	npleted on September 27, 2022.					
= 0=c :							
F 0584	483.10(i)(1)-(7)						
SS=E	Safe/Clean/Comfo	ortable/Homelike			1		İ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Environment

Bldg. 00

(X6) DATE

TITLE

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.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLE			.ETED
		155665	B. W	ING		09/21/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				701 HE	NRY STREET		
MAJESTIC CARE OF NORTH VERNON				NORTH	I VERNON, IN 47265		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN O			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	§483.10(i) Safe E						
		a right to a safe, clean, nomelike environment,					
		imited to receiving					
	_	oports for daily living safely.					
		pperiores damy inting carely.					
	The facility must p						
	- ',''	afe, clean, comfortable, and					
		ment, allowing the resident					
	•	personal belongings to the					
	extent possible.	nsuring that the resident					
	· · ·	and services safely and that					
		it of the facility maximizes					
		lence and does not pose a					
	safety risk.	ionee and deep not peep a					
		all exercise reasonable care					
	1 ' '	of the resident's property					
	from loss or theft.						
	8483 10(i)(2) Hou	sekeeping and maintenance					
	- ',''	ry to maintain a sanitary,					
	orderly, and comf	· ·					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,					
	- ',''	an bed and bath linens that					
	are in good condi	tion;					
	8483.10(i)(4) Priv	ate closet space in each					
	- ',''	specified in §483.90 (e)(2)					
	(iv);	, 3 · · · · · · (-/\ <del>-</del> /					
	1 - ,,,,,	quate and comfortable					
	lighting levels in a	ıll areas;					
	§483.10(i)(6) Con	nfortable and safe					
	- ',''	s. Facilities initially certified					
	1	990 must maintain a					
		e of 71 to 81°F; and					
	0.400.40 (%)						
	§483.10(i)(7) For	the maintenance of					

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Event ID:

C56311

Facility ID: 010996

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
		155665	B. W			09/21/2	
				CTREET	ADDRESS CITY STATE ZID COR		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ENRY STREET		
MAIEST	IC CARE OF NOR	TH VERNON			NRY STREET I VERNON, IN 47265		
	OANE OF NOR	III VERNON	1	NORTE	I VLINION, IN 41200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	comfortable soun	d levels.					
			F 03	584	what corrective action(		10/07/2022
		on, interview, and record			will be accomplished for the		
		failed to provide housekeeping			residents found to have bee	en	
	1	ain a sanitary, orderly, and			affected by the deficient		
		ike environment for 5 of 14			practice;	.	
		erved related to a clean			All rooms that were affected	by	
	environment. (Roo	ms 114, 115, 116, 104, and 105)			this deficient practice were		
	E. 1				cleaned according to the facil	lity	
	Findings include:				policy and inspected by the		
	1 D	0/20/22 / 10.51			Housekeeping Supervisor for	·	
		vation on 9/20/22 at 10:51 a.m.,			completion.		
	in Room 114 the sink had hair and dust behind the						
		d dirt debris on the floor			h		
	_	e wall trim was loose from the			how other residents		
		le. Throughout the floor there			having the potential to be		
	the beds.	lebris on the floor and under			affected by the same deficie		
	me beas.				practice will be identified an		
	During on absorred	tion on 9/21/22 at 1:40 p.m., in			what corrective action(s) wi	11	
	1	as dirt debris and hair behind a			be taken;	al to	
		d against the wall next to the			All residents had the potential be affected by this deficient	ai lU	
		and multiple dark dried spots.			practice		
		d dirt debris in the window			practice		
		ow seal, and on top of			· what measures will be	nut	
		it. In the corner to right of			into place and what systemi	-	
	window along the	_			changes will be made to		
	_	it there was dirt debris and			ensure that the deficient		
	_	ht corner next to the bathroom			practice does not recur;		
		nd bug, and dirt debris.			Housekeeping staff and		
	nad coowcos, a dead oug, and dift deoris.				supervisor were educated on	the	
	2. During an observ	vation on 9/20/22 at 3:09 p.m., in			housekeeping policies and		
	T	room toilet had stool spots			procedures by ED and outsid	le l	
		d several stool spots of the			account managers from our s		
		vas hair and dust behind the			vendor on 9/30/22.	,	
	toilet seat.				House keeping staff were in		
					serviced and checked off for		
	During an observat	tion on 9/21/22 at 1:35 p.m., in			completion on the proper way	y to	
		ere multi brown spots around			clean and deep clean resider		
the outside of the toilet bowl. There was paper				rooms.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/21/2022			
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF NORTH VERNON		701 H	STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE COMPLETION		
PREFIX TAG	and dirt debris between sink. There was a use the right side of the dated 9/19/22.  3. During an intervit Housekeeper 2 individual start with by the trash, clean the dispenser, and pape shower and the toile and mop the floor laissue she would just them know. She incompleted cleaning  During an observation Room 104 the tray to streaks on the frame along the base. The white and gray dust  4. During an observation floor sign. Under the there was a pillow of bed, there was a urdried yellow spots a to the window there  5. During an observation floor sign. Under the there was a urdried yellow spots a to the window there  5. During an observation floor sign. The fan hand covers. The base and covers. The base and covers. The base are the left of dresser, a white fan. The fan hand covers. The base	een the 3 drawer under the sed urine graduate sitting on sink, without being bagged,  ew on 9/21/22 at 10:19 a.m., cated to clean a room she wiping the tray tables, empty bathroom sink, dust the soap of towel holder, clean the set, then dust the resident room, ast. If there was a maintenance at talk to maintenance and let licated if she had time, she so filling out paper work, but indicated she had just Room 104.  on on 9/21/22 at 10:22 a.m., in table had white spots and and there was food debris are was food particles and under the resident's bed.  ation on 9/21/22 at 10:33 a.m., and room 105 and placed a wet to the bathroom on the floor at the head of the collastic and dust under the inal on the nightstand with around it. Under the bed next to was plastic pieces and dust.  ation on 9/21/22 at 2:15 p.m., in so plastic between the dresser was dirt and food debris to and around a free standing and black dust on the blades to of the fan was dusty. The	PREFIX TAG	how the corrective action(s) will be monitore ensure the deficient practive into place; The housekeeping supervisor/designee will resident rooms to confirm have been cleaned according and procedures we weeks, then monthly for 5 Audits will be submitted for monthly for 6 months to the committee until substantial compliance is achieved. See results slip below 95%, re-education and training until desired results are according to the completed.  10/9/22	ed to ctice quality pe put  eview they ding to ekly for 4 months. or review the QA il chould will occur chieved.  stemic		
	Lioset track had dirt	in it. In the bathroom the	1				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155665	B. WI	NG		09/21/	/2022
NAME OF B	DOLUBED OD GUIDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				701 HE	NRY STREET		
MAJESTIC CARE OF NORTH VERNON				NORTH	I VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION user, soap dispenser, and tank	+	TAG	BEHICLENCTY		DATE
	_	yer of white and gray dust.					
	The September Dec	ep Cleaning Schedule was					
	-	ON on 9/21/22 at 9:37 a.m. The					
	schedule indicated t	the following:					
	- On 9/19/22 the fol	llowing resident room was deep					
	cleaned: Room 114						
	- On 9/20/22, the fo	llowing rooms were deep					
	cleaned: Rooms 115	-					
	Housekeeping Supe staff got a hall list s be done, plus a stick common areas that usually clean the co	or on 9/21/22 at 3:09 p.m. the ervisor indicated everyday howing what was expected to key note of the additional staff was responsible for. Staff ommon areas first, then y tables tops were cleaned					
	-	should be dusted daily, but the swere cleaned during the deep					
		ng else deep clean or as					
	needed. When the d	leep cleaning was done, the					
		moved, cleaned around and					
	_	sor ensures compliance by					
	spot checking some	of the rooms.					
	from 9/20/22 to 9/2 did not clean his roo floor had dirt debris	ous interview and observation 1/22, Resident L indicated staff om very well. The bathroom sall over the floor. The excord indicated he was d oriented.					
	from 9/20/22 to 9/2 did not clean his wh wheelchair frame an	ous interview and observation 1/22, Resident E indicated staff neelchair. The resident's and wheels had a layer of white wheelchair seat had dried					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>		(X3) DATE SURVEY COMPLETED 09/21/2022		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF NORTH VERNON			STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION		
TAG	residue of food debrecord indicated he oriented.  During an anonyme from 9/20/22 to 9/2 did not clean her read and dust around the resident's clinical recognitively alert and During an anonyme from 9/20/22 to 9/2 did not clean his we and white and gray wheelchair. The reshe was cognitively  The current facility Disinfection of Endated August 2019 9/21/22 at 9:37 a.m. Environmental standisinfected according recommendations at those that come ininclude bed rails floors9surface cleaned on a regulation of the current facility not dated was proven 9:37 a.m. The Deep1" The CleaningRoom1. Dust/	ous interview and observation 21/22, Resident M indicated staff heelchair. There was dried food dust on the frame of the sident's clinical record indicated alert and oriented.  Topolicy titled, "Cleaning and vironmental Surfaces," and a was provided by the DON on a. The Policy indicated, "arfaces will be cleaned and ing to current CDC1. C. non-critical items are contact with intact skinbedside tables, furniture, and is (e.g., floors, tabletops) will be	TAG	DEFICIENCY		DATE		
	dressers and night	you can or sweep under stands. 4. Dust TV. 5. Wipe apty trash cans and wipe them						

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out or replace them. 7. Clean off windows and the

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CTATEMENT OF REFLICIENCIES AND RECURS OF THE PROPERTY OF THE P		(3/2) 3.4	(X2) MULTIPLE CONSTRUCTION			(V2) DATE CHRYEY				
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ſ ′		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00	COMPI				
		155665	B. W	ING		09/21	/2022			
NAME OF B	DOLUDED OD GUEN IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-				
NAME OF P	ROVIDER OR SUPPLIEF	C		701 HE	NRY STREET					
MAJESTIC CARE OF NORTH VERNON				NORTH VERNON, IN 47265						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE		COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE			
	ledges. 8. Dust the	blinds. 9. Dust over the bed								
	light fixtures and co	eiling vents14. Clean out								
	corners. 15. Sweep	and mop roomBathroom: 1.								
	Wipe down sink, sh	nower, and handrails. 2. Clean								
	mirror. 3. Dust soap	and paper towel dispenser. 4.								
	Clean inside and ou	tside of the toilet (also the								
	base)6. Empty tra	ash7. Sweep and mop"								
	The current facility	Housekeeping Daily list and								
	not dated was provi	ded by the DON on 9/21/22 at								
	9:37 a.m. The Daily	list indicated, "Rooms:								
	check trash cans	replace bags. Clean and wipe								
		tables, bed rails, nightstands,								
	dressers, windowsil	lls, door frames etc.)Sweep								
	and mop the floors	Bathrooms: wipe down sink,								
	paper towel holders	s, and soap dispensersuse								
	* *	inside of the bowl but make								
		the outside and the bottom								
	-	ext to the toilet and in the								
	showers"									
	This Federal tag rel	ates to Complaints IN00390208.								
		-								
	3.1-19(f)									

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