CENTERS FOI	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155665	B. W	ING		06/12	2/2025	
NAME OF I	DDOVIDED OD CUDDI IEI	D.	•	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	K		701 HENRY STREET				
MAJEST	IC CARE OF NOR	TH VERNON		NORTH VERNON, IN 47265				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN		1	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Dida 00								
Bldg. 00	This visit was for a	Recertification and State	EO	200	The greation and submissis	n of		
	Licensure Survey.	Recertification and State	F 0000		The creation and submission of			
	Licensule Survey.				this Plan of Correction does not constitute an admission by this			
	Survey dates: June	8, 9, 10, 11, and 12, 2025			provider of any conclusion s			
	Survey dutes, sune	0, 9, 10, 11, und 12, 2023			in the statement of deficience			
	Facility number: 0	10996			any violation of regulation.	•		
	Provider number: 155665 AIM number: 200232210 Census Bed Type:				provider respectfully reques			
					State Report Plan of Correc			
					considered the Letter of Cre			
					Allegation. This provider alle	eges		
	SNF/NF: 101				compliance as of June 29, 2	2025.		
	Total: 101				The facility respectfully requ	ests a		
					desk review for this Plan of			
	Census Payor Type	e:			Correction relative to the lov	V		
	Medicare: 2				scope and severity of this su	-		
	Medicaid: 92				in lieu of a post-survey revis	it.		
	Other: 7							
	Total: 101							
	T 1 0	Cl. (Ct. 4 E' 1' '4 1'						
	accordance with 41	reflect State Findings cited in						
	accordance with 41	10 IAC 16.2-3.1.						
	Quality raviasy con	npleted on June 16, 2025.						
	Quality leview con	inpleted on Julie 10, 2023.						
F 0554	483.10(c)(7)							
SS=D	` ' ' '	min Meds-Clinically Approp						
Bldg. 00		,,,,,						
	Based on observati	on, interview, and record	F 0:	554	F554 Resident Self-Admin	Meds	06/29/2025	
	review, the facility	failed to ensure residents were			- Clinically Appropriate			
	deemed appropriate	e to self-administer medications			What corrective action(s) wi	ll be		
	prior to leaving me	dications at the residents			accomplished for those resi			
	bedside unsupervis	ed for 2 of 2 residents			found to have been affected			
	reviewed for self-a	dministering medications.			deficient practice?			
	(Residents 78 and 3	37)			1 Residents 78 and 37 w	ere		
					identified during the time of			
	Findings include:				observation. Licensed nurse	s and	1	

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

(X6) DATE

QMAs educated on

TITLE

Daniel Kern Executive Director 06/25/2025

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HX2O11 Facility ID: 010996 If continuation sheet Page 1 of 24

06/30/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/12/2025 155665 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1. During an observation and interview, on self-administration of medications 06/10/25 at 11:49 A.M., Resident 78 was reclining by June 29, 2025. on her bed in her room. A medication cup was How other residents having the sitting on the resident's over the bed table. The potential to be affected by the medication cup contained one half of a round same deficient practice will be white tablet and one small red and white capsule. identified and what correction The resident indicated the medications were action(s) will be taken? Lyrica (a pain medication) and her anxiety pill. She All residents have the did not know the name of her anxiety pill. potential to be affected. Sometimes the staff left them at the bedside and DNS/ADNS will conduct an sometimes they stood at the bedside and watched audit of the facility for residents her take them. If the staff member knew her, they with 'Medication would leave them at the bedside. If they did not Self-Administration Safety Screen' know her, they would stand there and watch her evaluations on June 22, 2025. take them. No staff members were in or near the DNS/ADNS will complete immediate area of the resident's room. Other new 'Medication residents were independently mobile and Self-Administration Safety Screen' propelling themselves down the hallway. evaluations on any resident(s) wishing to self-administer The clinical record was reviewed on 06/11/25 at medications by June 23, 2025. 10:05 A.M. A Quarterly Minimum Data Set (MDS) DNS/ADNS will conduct a assessment, dated 05/05/25, indicated the resident facility-wide spot check during was cognitively intact. The resident's diagnoses medication pass to check for included, but were not limited to, stoke, anxiety, medications left at bedside by depression, and respiratory failure. June 24, 2025. Licensed nurses and QMAs During an interview, on 06/11/25 at 11:40 A.M., educated on self-administration of the DON indicated there were no residents medications by June 29, 2025. currently in the building who self-administered What measures will be put into their medications. place and what systemic changes 2. During an observation and interview, on will be made to ensure that the 06/08/25 at 10:19 A.M., Resident 37 was sitting on deficient practice does not recur? the side of the bed in her room. There were three DNS/ADNS will conduct an medication cups sitting on the resident's bedside audit related to medications left at table. One medication cup contained three small the bedside 2x/week x4 weeks, white capsules, the second one contained a large weekly x4 weeks, and monthly x6 white capsule, and the third one contained a large months. round pill broke in half, a medium round peach DNS/ADNS will conduct an colored pill, one large round pill, one medium audit on new admission(s) and/or round white pill. The resident indicated the readmission(s) for residents

HX2O11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM			COMPL	ETED
		155665	B. WING 06/12/2025			2025	
				CTDEET A	DDDFGG CITY GTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGE		TILVEDNON.			NRY STREET		
WAJEST	IC CARE OF NORT	H VERNON		NORTH	I 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	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.2	DATE
	medications were h	ers and the nurse had left them			wanting to self-administer		
	for her to take. No s	staff members were in or near			medications and the 'Medication'	on	
	the resident's room	or in the hallway outside the			Self-Administration Safety Scr	een'	
	resident's room.				evaluation(s) Monday-Friday		
					during clinical meeting x6 mor	ıths.	
	The clinical record	was reviewed on 06/10/25 at			How the corrective action(s) w		
	11:03 A.M. A Quar	terly MDS assessment, dated			monitored to ensure the deficie	ent	
	04/21/25, indicated	the resident was cognitively			practice will not recur, i.e., who	at	
	intact. The resident	s diagnoses included, but			quality assurance program wil		
	were not limited to,	hypertension, heart failure,			put into place?		
	dementia, anxiety, a	and depression.			1 For quality assurance, the	e	
					DNS or ADNS will review any		
	During an interview, on 06/11/25 at 9:54 A.M.,				findings during clinical meeting	g,	
	Licensed Practical Nurse (LPN) 3 indicated				with subsequent correction ac	tion	
	medications should not have been left at the				and education for identified sta	aff	
	resident's bedside. A	A resident should be watched			members.		
	while they take thei	r medications unless they were			2 Findings will be reported	at	
	assessed to self-adn	ninister.			the QA meeting monthly x6		
					months or until substantial		
	During an interview	y, on 06/11/25 at 11:17 A.M.,			compliance has been determir	ned.	
	the DON indicated	the resident did not have a					
		assessment. She was not safe			Date corrections will be compl	eted	
	to self-administer a	ny of her medications.			by: June 29th 2025		
	· · · · · · · · · · · · · · · · · · ·	policy titled, "Medication					
		ted 01/02/2024, was provided					
	1 -	11/25 at 11:40 A.M. The policy					
		nless the resident has been					
	assessed for safe se						
		ations are not to be left					
		esident to consume at a later					
	time."						
		N SELF-ADMINISTRATION					
		" records for the last six months					
		re provided by the Director of					
		06/11/25 11:15 A.M. There was					
	1 -	this resident. The record, with					
		04/02/25, indicated the					
	resident required as	sistance with medication					

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155665	B. WING		06/12/2025	
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD ENRY STREET		
MAJESTI	IC CARE OF NORT	TH VERNON		H VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		the "Resident may NOT				
		lications". Ongoing occur at a minimum of				
	quarterly.	occur at a minimum of				
	quarterry.					
	3.1-11(a)					
F 0657	483.21(b)(2)(i)-(iii))				
SS=D	Care Plan Timing					
Bldg. 00						
	Based on record rev	view and interview, the facility	F 0657	F657 Care Plan Timing and	06/29/2025	
	failed to revise a res	sident's care plan related to		Revision		
prophylactic antibiotic usage for 1 of 21 residents			What corrective action(s) will be	oe e		
	reviewed for care p	lans. (Resident 58)		accomplished for those reside	nts	
				found to have been affected by	y the	
	Findings include:			deficient practice?		
				1. Resident 58 was identified		
		al record was reviewed on		during the time of observation.		
		M. A Quarterly Minimum Data		deficiency was corrected on Ju	une	
		ed 02/28/25, indicated the		12, 2025.		
		ately cognitively impaired. The		How other residents having the	е	
	-	s included, but were not		potential to be affected by the		
	limited to, stroke, d			same deficient practice will be		
		resident had an indwelling		identified and what correction		
	urinary catheter.			action(s) will be taken? 1. All residents on prophylaction		
	The recident's curre	ent physician's orders included,		1 ' ' '		
	but were not limited	1 2		antibiotics have the potential to affected.	o be	
	out were not minted	a to the following.		2. DNS/ADNS will conduct a		
	- An open-ended ph	nysician's order, with a start		facility-wide audit for residents	on	
		or Cephalexin (an antibiotic) 500		prophylactic antibiotics and rev		
		aily for prophylaxis for recurrent		the care plan, if needed, by Ju		
	UTIs (Urinary Trac			13, 2025.		
		•		3. RAI Specialist will educate		
	The resident's Elect	tronic Medication		clinical management on care p	olan	
	Administration Rec	ords for February, March,		accuracy and compliance with		
	April, May, and Jur	ne 2025 indicated the resident		antibiotic medications by June		
	received the antibio	otic daily since 02/13/25.		2025.		
				What measures will be put into		

The resident's complete Care Plan Report was

place and what systemic changes

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION (X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG <u>00</u>	COMPLETED	
		155665	B. WING		06/12/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAC	IX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	RIATE COMPLETION DATE	
1710		25 at 10:45 A.M. and lacked a	1710	will be made to ensure that	5.112	
		ophylactic antibiotic usage.		deficient practice does not r 1. DNS/ADNS will conduct a	ecur?	
	During an interview, on 06/12/25 at 11:05 A.M.,			audit related to prophylactic		
		sing indicated the resident's		antibiotics and care plan ac	-	
		resident had a history of UTIs.		2x/week x4 weeks, weekly x		
		gist ordered the prophylactic ity called to see about		weeks, and monthly x6 mon 2. DNS/ADNS will audit new		
		ntibiotic, but the urologist		admission(s) and/or	'	
	_	to continue to receive the		readmission(s) for prophylad	ctic	
		he resident's care plan should		antibiotics and care plan ac		
	have been updated to indicate she was receiving			Monday-Friday during clinic	-	
	the prophylactic antibiotic.			meeting x6 months.		
				How the corrective action(s)		
	· ·	policy, titled "Comprehensive		monitored to ensure the def		
		1/01/24, was provided by the		practice will not recur, i.e., v		
		on 06/12/25 at 1:42 P.M. The .The comprehensive care plan		quality assurance program v	VIII be	
		ninimumservicesto maintain		put into place? 1. For quality assurance, the	DNS	
		it's highest practicable		or ADNS will review any find		
	_	nd psychosocial well-being"		during clinical meeting, with	_	
				subsequent correction actio		
	3.1-35(b)(1)			education for identified staff		
				members.		
				2. Findings will be reported		
				QA meeting monthly x6 more		
				until substantial compliance	has	
				been determined.		
				Date corrections will be com	npleted	
				by: June 29th 2025		
F 0684	483.25					
SS=D	Quality of Care					
Bldg. 00	Quality of Oale					
J. 22	Based on record rev	view and interview, the facility	F 0684	F684 Quality of Care	06/29/2025	
		sician's orders related to hold		What corrective action(s) wi		
	1 ~	iac medications for 3 of 21		accomplished for those resi	dents	
		for quality of care. (Residents		found to have been affected	by the	
	58, 15, and 7)			deficient practice?		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155665	B. W	ING		06/12/	2025
		l	<u> </u>	STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			NRY STREET		
MAIEST	IC CARE OF NORT	TH VERNON			I VERNON, IN 47265		
IVIAJEST	OANE OF NOR	III VERNON		NORTE	. VLINION, IIN 47 200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					1. Residents 58, 15, and 7 v	vere	
Findings include:				identified during the time of			
					observation. Dr. Neese review	/ed	
		nical record was reviewed on			hold parameters for the identif		
		M. A Quarterly Minimum Data			residents on June 16, 2025 wi	th	
		ent, dated 02/28/25, indicated			no new orders. Licensed nurs	ses	
		oderately cognitively impaired.			and QMAs educated on follow	ring	
	_	noses included, but were not			NP/MD orders related to hold		
		ypertension, and coronary			parameters by June 29, 2025.		
	artery disease.				How other residents having th	е	
					potential to be affected by the		
	The resident's current physician's orders included,				same deficient practice will be	!	
but were not limited to, an open-ended order, with				identified and what correction			
		1/25, for Midodrine 10 milligram			action(s) will be taken?		
		mes a day. The resident was to			All residents receiving car		
		y mouth, at 8:00 A.M., 12:00			medications with hold parame		
		I., for hypotension. The	have the potential to be affected.				
		be held if the resident's systolic			2. DNS/ADNS will conduct a		
	blood pressure (top	number) was greater than 120.			audit of the facility for resident		
					with cardiac medications with		
		dication Administration Record			parameters on June 23, 2025.		
		025 indicated the resident			3. Licensed nurses and QM	As	
		ation when the systolic blood			will be educated on following		
	_	20 on the following dates and			NP/MD orders related to cardi		
	times:				medications with hold parame	ters	
	0.05/05/5-				by June 29, 2025.		
		2:00 P.M., when the blood			What measures will be put into		
	pressure was 136/8				place and what systemic chan	•	
		00 P.M., when the blood			will be made to ensure that the		
	pressure was 140/6				deficient practice does not rec		
		2:00 P.M., when the blood			1. DNS/ADNS will conduct a	n	
	pressure was 122/6				audit of the administration of		
		2:00 P.M., when the blood			cardiac medications with hold		
	pressure was 124/7				parameters to determine if		
		2:00 P.M., when the blood			medications given or held per	1	
	pressure was 128/7	· ·			NP/MD order 2x/week x4 wee		
		00 A.M., when the blood			weekly x4 weeks, and monthly	/ X6	
	_	2, at 12:00 P.M., when the			months.		
		132/70, and at 8:00 P.M., when			2. DNS/ADNS will conduct a		
the blood pressure was 124/78,		1		audit on new admission(s) and	d/or		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/12/2025	
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 10 A.M., when the blood	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DATE
	pressure was 128/74 blood pressure was - On 05/16/25 at 8:0 pressure was 128/62 - On 05/20/25 at 12 pressure was 126/70 blood pressure was - On 05/21/25 at 8:0 pressure was 136/68 blood pressure was the blood pressure was the blood pressure was 128/70 - On 05/24/25 at 12 pressure was 123/62 - On 05/29/25 at 8:0 pressure was 128/70 pressure was 133/69 Resident 15 was rev A.M. A Quarterly N 03/06/25, indicated intact. The resident' were not limited to, neurogenic bladder, had an indwelling u An open-ended phy of 12/11/24, indicat Losartan (a blood p once a day for hype hold the medication was less than 120 or 60. The March, April, N indicated the reside when their systolic 120 on the followin	200 P.M., when the blood 3, and at 8:00 P.M., when the blood 0, and at 8:00 P.M., when the 123/67, 200 A.M., when the blood 3, at 12:00 P.M., when the 124/72, and at 8:00 P.M., when was 129/68, 200 P.M., when the blood 3, and 200 A.M., when the blood 3, and 200 A.M., when the blood 3, at 8:00 P.M., when the blood 3, and 300 A.M., when the blood 3, at 8:00 P.M., when the blood 3, and 300 A.M., when the blood 3, at 8:00 P.M., when the blood 3, and 300 A.M., when the blood 3, at 8:00 P.M., when the blood 3, and 300 A.M., when the blood 3, at 8:00 P.M., when the blood 4, at 8:00 P.M., when the blood 5, at 8:00 P.M., when the blood 5, and 300 P.M., when the blood 5, at 8:00 P.M., when the blood 5,		readmission(s) for residents cardiac medications and collaborate with NP/MD if he parameters are needed Monday-Friday during clinic meeting x6 months. How the corrective action(s) monitored to ensure the def practice will not recur, i.e., v quality assurance program v put into place? 1. For quality assurance, to DNS o ADNS will review an findings during clinical meet with subsequent correction and education for identified members. 2. Findings will be reporte the QA meeting monthly x6 months or until substantial compliance has been deterred. Date corrections will be comby: June 29th 2025	old al) will be icient what will be the y ing, action staff d at mined.

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Event ID:

HX2O11 Facility ID: 010996

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/12/2025			
	PROVIDER OR SUPPLIEF		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 PLICE IDENTIFYING DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODER OF THE APPRODE OF THE APPROD	D BE COMPLETION		
TAG	- On 03/11/25 wher - On 03/19/25 wher - On 04/01/25 wher 101/62, - On 04/03/25 wher 107/65, - On 04/06/25 wher 101/65, - On 04/10/25 wher 106/68, - On 04/23/25 wher 108/60, - On 05/01/25 wher 108/60, - On 05/01/25 wher 109/66, - On 05/21/25 wher 108/63, and - On 06/06/25 wher 103/63. 3. The clinical record on 06/10/25 at 02:3 assessment, dated 0 was cognitively intaincluded, but were anemia, hypertensic diabetes, seizure disdepression. A current, open-enc start date of 04/07/2 to receive Midodrin 8:00 A.M., 12:00 P were to hold the mes systolic blood press	a the blood pressure was 97/55, in the blood pressure was 91/50, in the blood pressure was 91/50, in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident and the indicated the resident was in the blood pressure was end for Resident's diagnoses in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident was in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident was in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident was in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident was in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident was in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident was in the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident and the blood pressure was end for Resident 7 was reviewed 2 P.M. A Quarterly MDS 5/30/25, indicated the resident 8 was end for Resident 7 was reviewe	TAG	DEFICIENCY)	DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HX2O11 Facility ID: 010996

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STATEMEN	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>			COMPLETED	
		155665	B. W	ING		06/12/2025		
e e e			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	R		701 HE	NRY STREET			
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	I VERNON, IN 47265			
(X4) ID		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' DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE	
	on the following da	pressure was greater than 120						
	on the following da	ues and times.						
	- On 04/27/25 at 8:	00 A.M., when the blood						
	pressure was 129/5							
	- On 04/28/25 at 12	2:00 P.M., when the blood						
	pressure was 136/6	9 and 8:00 P.M., when the						
	blood pressure was							
		2:00 P.M., when the blood						
	pressure was 129/4							
		00 A.M., when the blood						
	pressure was 134/50 and 12:00 P.M., when the							
	blood pressure was 138/48, - On 05/17/25 at 8:00 A.M., when the blood							
		2 and 12:00 P.M., when the						
	blood pressure was							
	_	00 P.M., when the blood						
	pressure was 151/6							
	-	2:00 P.M., when the blood						
	pressure was 136/4							
	- On 05/29/25 at 8:	00 P.M., when the blood						
	pressure was 127/4	5,						
	- On 06/03/25 at 8:0	00 A.M., when the blood						
	pressure was 140/6							
		00 P.M., when the blood						
	pressure was 122/6							
		2:00 P.M., when the blood						
	pressure was 128/5							
		2:00 P.M., when the blood						
	pressure was 143/5	0.						
	During an interview	v, on 06/11/25 at 11:10 A.M.,						
		Nurse 2 indicated if a resident's						
	medication had hol	d parameters, she would obtain						
		if they were outside the						
	parameters to give	the medication then she would						
	not administer it to	the resident. She would						
		MAR that the medication was						
		ue to it being outside the						
	parameters.							

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM			ETED
		155665	B. WI	NG		06/12/2025	
	ROVIDER OR SUPPLIER		•	701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
(X4) ID	SUMMARY S	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 APPROPRIATE	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
F 0690 SS=D Bldg. 00	Administration" wa provided by the Dir 11:40 A.M. The pol record vital signs, w physician orders. W medication for those physician's prescrib 3.1-37(a) 483.25(e)(1)-(3) Bowel/Bladder Inc. Based on observation review, the facility of placement of a urinaresident that received Urinary Tract Infect reviewed for indwel (Resident 58) Findings include: On 06/09/25 at 10:2 observed in her room urinary catheter draws visible in the turn floor next to the bed position. About two was resting on the both the bed and the floor Resident 58 was obroom on 06/10/25 a catheter drainage bar catheter dr	continence, Catheter, UTI on, interview, and record failed to ensure proper ary catheter drainage bag for a ad prophylactic antibiotics for tions (UTIs) for 1 of 4 residents lling urinary catheters. 28 A.M., Resident 58 was m in bed. The resident's inage bag was hanging on the k yellow urine with sediment tibing. There was a mat on the l and the bed was in a lower oinches of the drainage bag hare floor in the space between r mat. served in the A-Hall dining t 12:12 P.M. The resident's ag was hanging under her out an inch of the drainage bag	F 06	590	F690 Bowel/Bladder Incontinence What corrective action(s) will be accomplished for those resided found to have been affected by deficient practice? 1. Resident 58 continues to reside at the facility with urinar catheter. Deficiency was corre at the time of observation. 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 urinary catheters have the potential to affected. 2. DNS/ADNS will conduct a audit of the facility for residents with urinary catheters by June 2025. 3. All staff will receive educa on Urinary Catheter care and Infection Control related to	nts y the y the y cted e	06/29/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED	
		155665	B. WI	B. WING 06/12/2025			/2025	
	PROVIDER OR SUPPLIER			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	06/11/25 at 3:24 P.N. Set assessment, date resident was moder resident's diagnoses limited to, stroke, dinsufficiency. The rurinary catheter. The resident physic not limited to the form of 02/13/25, formilligrams, once date of 02/13/25, formilligrams, once da	ian's orders included, but were ollowing: sysician's order, with a start or Cephalexin (an antibiotic) 500 illy for prophylaxis for recurrent received the medication every 7, on 06/10/25 at 2:57 P.M., the Support Nurse indicated no g urinary catheter should be policy, titled "Indwelling (02/24, was provided by the			catheters by June 29, 2025. What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recontrol related to correct placement of catheter bags 2x/week x4 weeks, weekly x4 weeks, and monthly x6 month How the corrective action(s) we monitored to ensure the deficipractice will not recur, i.e., who quality assurance program will put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting with subsequent correction act and education for identified stamembers. 2. Findings will be reported at the QA meeting monthly x 6 months or until substantial compliance has been determined.	ages e cur? ction s. vill be ent at l be g, ttion aff at		
	policy indicated, "				Date corrections will be compl by: June 29th 2025	eted		
	3.1-41(a)(2)							
F 0755 SS=D Bldg. 00) /Pharmacist/Records on, interview, and record	F 07	155	F755 Pharmacy		06/29/2025	
	review, the facility	failed to follow physician's	10/		Services/Procedures/Pharma	<u>aci</u>	00/27/2023	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/12/2025 155665 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 21 residents reviewed for pharamcy services. What corrective action(s) will be (Resident 23) accomplished for those residents found to have been affected by the Findings include: deficient practice? 1. Resident 23 was identified During an observation, on 06/09/25 at 8:48 A.M., during the time of observation. Dr. RN 4 sanitized her hands and prepared Neese was notified on June 11, medications for Resident 23. After placing all the 2025 with no new orders. Kelsey medications into a cup that included, but was not Brown, NP gave new order to limited to, a Potassium Chloride Extended-Release change potassium to liquid on 10 milliequivalent (MEQ) tablet, she poured the June 13, 2025. medications into a pouch, crushed the How other residents having the medications, placed them back into the medication potential to be affected by the cup, and added applesauce. The medications were same deficient practice will be administered to the resident. identified and what correction action(s) will be taken? The current, open-ended physician's order, with a 1. All residents receiving start date of 07/13/23, indicated the resident was potassium chloride ER have the to receive Potassium Chloride 10 MEO potential to be affected. Extended-Release tablet, once a day. The staff 2. DNS/ADNS will conduct an were to place the medication in applesauce and audit of the facility for residents allow it to dissolve. The tablet was not to be with potassium chloride ER on crushed. June 22, 2025. 3. DNS/ADNS will conduct an During an interview, on 06/11/25 at 12:07 P.M., the audit of all residents in the facility Director of Nursing (DON) indicated if a that require crushed medications. physician's order stated to not crush a medication, DNS/designee will collaborate with then it should not have been crushed. NP/MD for orders for liquid potassium, if necessary, by June The current facility policy titled, "Medication 23, 2025. Administration" was dated 01/02/2024, was 4. DNS/ADNS/Unit Manager will provided by the Director of Nursing on 06/11/25 at add 'Do not crush' on all 11:40 A.M. The policy indicated, "...Administer potassium chloride ER orders and medication as ordered in accordance with place 'Do not crush' labels on the manufacturer specifications...Crush medications potassium chloride ER blister as ordered. Do not crush medications with "do packs by June 23, 2025. not crush" instructions..." 5. Licensed nurses and QMAs will be educated on 'Do Not Crush 3.1-48(c)(2)Meds,' specifically potassium chloride ER by June 29, 2025.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/30/2025 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155665	B. WING		06/12/2025
MAJESTI	ROVIDER OR SUPPLIES	TH VERNON	701 HE NORTI	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	6. Licensed nurses and QM will receive a copy of 'Do Not Crush Med' list by June 29, 20 What measures will be put into place and what systemic char will be made to ensure that the deficient practice does not reconstruction of potassium chloride to determine medication was administered appropriately 2x/week x4 week weekly x4 weeks, and monthly months. 2. DNS/ADNS will conduct a audit on new orders, new admission(s), and/or readmission(s) for residents of potassium chloride ER for 'do crush' on medication order, 'do crush' label on medication blist pack, and collaborate with NP if liquid form is needed during clinical meeting x6 months. 3. DNS/ADNS will provide not hired staff, i.e. licensed nurses and/or QMAs with a copy of 'Double to the corrective action(s) when the correc	As DATE AS DA
				with subsequent correction ac	tion

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members.

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and education for identified staff

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CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/12/2025				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
				Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined by: June 29th 2025	ned.			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs							
	failed to store medication carts ob medication carts ob medication Carts) Findings include: The A-Hall Medication 10/11/25 at 10:14 A Nurse 2. The follow - an unopened vialue of the state of the st	of insulin Lispro for Resident I, cort inhaler for Resident 17 that rol inhaler for Resident 17 that tion Cart was observed on A.M., with LPN 6. The following ler for Resident 65, that was tion Cart was observed on	F 0761	Biologicals What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? Residents 59, 17, 65, and were identified during the time observation and insulin and inhalers were discarded per far policy. Medication re-ordered f pharmacy. 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? All residents receiving insum and inhalers have the potential be affected. DNS/ADNS will conduct a audit of medication carts by Ju 24, 2025. Nursing staff to be education Storage and Labeling of Medication guidelines by June 2025.	nts y the d 16 of cility from e			
		A.M., with LPN 3. The following		What measures will be put into)			

was observed:

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place and what systemic changes

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/12/2025				
	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 TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	was 3/4 full that wa it came from the ph that as the open date. During an interview Director of Nursing should have dates of medication cart. If they should have be albuterol inhalers we they were opened, were good for 90 d had open dates and they expired. The current "Produce revision date of Ma DON on 06/11/25 a indicated, "Insuli [expiration] date	Humalog for Resident 16 that as undated. The nurse indicated harmacy on 06/08/25 and wrote to on the vial. It won 06/11/25 at 11:37 A.M., the g (DON) indicated all insulins on them if they were in the they were not opened, then een in the refrigerator. The were good for one year after the Symbicort and Combivent ays. The inhalers should have should be discarded after ct Expiration Dates" with a ay 2023, was provided by the at 1:38 P.M. The policy in vialsRoom Temperature Exp 28 daysAlbuterol [aerosol]12 int3 monthsSymbicort90		will be made to ensure that the deficient practice does not red 1 DNS/ADNS will audit medication carts at random for date and expired insulin pensor and inhalers 2x/week x4 week weekly x4 weeks, and monthly months. How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting with subsequent correction and education for identified standard education for identified education for ide	r/vials ss, y x6 vill be ent at I be			
F 0812 SS=E Bldg. 00	Based on observati failed to follow app the use of hair cove foods in a sanitary and outdated foods observations, and fi infection control gu	re/Prepare/Serve-Sanitary on and interview, the facility propriate guidelines related to erings in the kitchen and store manner related to unlabeled and for 1 of 3 kitchen ailed to follow appropriate aidelines related to hand dining observations. (D-Hall	F 0812	F812 – Food Procurement, Storage/Prepare/Serve-Sanit What corrective action(s) will be accomplished for those reside who found to have been affect by the deficient practice? All items found to be improperly dated at the time of observation were immediately	pe ents ted			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/12/2025 155665 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: removed from the refrigerators and discarded 1. During the initial tour of the kitchen on 06/08/25 Staff member that was at 10:10 A.M., Activity Aide 12 was observed in found to not have been wearing a the kitchen preparing drinks near the coffee pots. beard restraint was educated on The Activity Aide had a long beard the touched proper procedures when entering his collar bone that was not contained in a beard the kitchen to retrieve items for net activities including proper hair/beard restraints to be used. The kitchen refrigerators were observed on Staff who serve food in 06/08/25 at 10:12 A.M. and contained the facility will be educated on proper following: hand washing procedures during meal service. - An undated rectangular metal pan covered in plastic wrap that contained tuna salad, How other residents having the potential to be affected by the - A large, lidded container 3/4 full of Dijon pork. same deficient practice will be The label indicated the pork was prepared on identified and what correction 06/02/25, and was to be used 06/05/25, action(s) will be taken? A facility wide inspection of - A 1/3rd full gallon of milk, with a best by date of all refrigerators containing food 05/26/25, and meant for residents was initiated and no further items were found - A 1/3 full clear pitcher of tomato juice. The label improperly labeled/dated. All staff indicated the juice was made on 06/03/25 and was to be in-serviced on proper hair to be used by 06/06/25. restraints to be worn while in the kitchen and hand washing During an interview, on 06/08/25 at 10:18 A.M., procedures during food service. the Assistant Dietary Manager indicated the What measures will be put into Activity Aide's beard should have been covered. place and what systemic changes The tuna salad should have been labeled with a will be made to ensure that the "prepared on" date. The pork, milk, and tomato deficient practice does not recur? juice were expired and should have been thrown Staff in-services to be out. provided for all staff regarding proper procedures for labeling and The current facility policy, titled "Staff Attire", dating food stored, Proper usage dated 10/2023, was provided by the Administrator of hair/beard restraints, and proper on 06/12/25 at 10:26 A.M. The policy indicated, handwashing procedures to be "...All staff members will have...facial hair properly followed during food/meal service. restrained..." In-services to be completed by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/12/2025 155665 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 6/25/2025 The current facility policy, titled "Food Storage: Food service manager or Cold Foods", dated 02/2023, was provided by the Manager in Training will perform Administrator on 06/12/25 at 10:26 A.M. The audits refrigerators throughout policy indicated, "...All foods will be...labeled and facility, hair/beard restraint usage dated..."2. The D-Hall Dining room meal service in kitchen and will monitor and was observed on 06/08/25 at 11:51 A.M. Certified audit staff during resident meal Nurse Aide (CNA) 9 pushed a chair in the dining service for proper hand hygiene 5x room using her hands, touched her nose with her weekly x6 months. This plan will left hand, sat down in a chair by three residents be revised as warranted. Audits to sitting at the table nearest the kitchen door, start 6/23/2025 touched her face and ear with her right hand, then served a meal tray to Resident 6. CNA 9 touched How the corrective action(s) will be the resident's plate and napkin, unrolled the monitored to ensure the deficient napkin, took out the silverware, removed the foil practice will not recur, i.e., what from the resident's baked potato, chopped it up quality assurance program will be with the resident's fork holding the fork in her put into place? right hand, opened the resident's sour cream For quality assurance, the packet, and squirted the sour cream on the facility Administrator or Director of resident's potato. The resident picked up the fork Nursing will review any findings 5 and fed herself. CNA 9 used hand sanitizer then days a week during morning served a tray to another resident. meeting, with subsequent corrective action and education for During an interview, on 06/11/25 at 2:11 P.M., identified staff members. CNA 9 indicated when serving meal trays, staff Findings will be reported at were to use hand sanitizer after each tray and the QA meeting monthly x6 wash their hands after three to five trays. Staff months and will continue until were not to touch themself before serving meal 100% compliance is achieved. trays. Date corrections will be completed The current Handwashing-Hand Hygiene policy, by: June 29th 2025 with an effective date of 03/01/25, was provided by the DON on 06/12/25 at 10:26 A.M. The policy indicated, "...If hands are not visible soiled, use an alcohol-based hand rub...for all the following situations... After direct contact with residents...After contact with objects...in the immediate vicinity of the resident..."

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3.1-21(i)(2)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED			
		155665	B. WING		06/12/2025			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265					
				T VERWORK, IIV 47200				
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE			
	3.1-21(i)(3)							
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention							
	Based on observation	on, interview, and record	F 0880	F880 Infection Prevention &	06/29/2025			
	review, the facility	failed to follow appropriate		Control				
		idelines during a wound		What corrective action(s) will be	pe			
		d for indwelling urinary		accomplished for those reside				
		nt for 4 of 21 residents		found to have been affected b	y the			
		ion control. (Residents 2, 100,		deficient practice?				
	101, and 15)			1. Resident 2, 15, 100, 101	.,			
	Findings include:			continues to reside at the facil with urinary catheter. Deficien	,			
	1 A record duoscin	a abanca for Booklant 2 was		was corrected at the time of				
		g change for Resident 2 was 25 at 10:41 A.M., with Licensed		observation. 2. Resident 2 continues to res	ido			
		'N) 7 and LPN 10. The LPN's		at the facility with wounds. Sta				
		the hallway from a cart of		educated on wound care and	111			
	-	t to the resident's room door.		infection control related to wor	ınd			
		eves. With her gloves on, she		care on June 29, 2025.				
	_	cket on her scrubs, got her		How other residents having th	e			
	treatment cart keys	out, and used them to open		potential to be affected by the				
	the cart. She gather	ed treatment supplies, took		same deficient practice will be	,			
	them into the reside	ent's room, laid the supplies on		identified and what correction				
		went into the bathroom located		action(s) will be taken?				
		m, did not turn on the water or		All residents with urinary				
		e out with paper towels, and		catheters and wounds have th	ne			
		s on the over bed table. LPN		potential to be affected.				
	-	gauze pads and made a stack,		2. Staff will be educated on				
		pads with her gloved hands.		Urinary Catheter Care, Wound				
		e resident towards LPN 7, who		Care, Infection Control related				
		their side. LPN 10 sprayed a		catheters, and Infection Control				
		biclens, on a gauze pad from d the resident's tennis ball		related to wound care (i.e. har washing) by June 29, 2025.	iu			
		nd located on her left buttock.		What measures will be put into				
		wound with more gauze pads in		place and what systemic chan				
	•	he bleeding. She applied a		will be made to ensure that the	-			
		protective paste, Triad, when		deficient practice does not rec				

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LPN 7 indicated the treatment was supposed to be

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1. DNS/designee will audit

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155665	B. WING 06/12/2025			/2025	
		<u> </u>	1	CTDEET /	ADDRESS CITY STATE 7ID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
MAJEST		TH VERNON			NRY STREET I VERNON, IN 47265		
IVIAJEST	IC CARE OF NORT	TO VERNON		NORTE	1 VERNON, IN 4/200		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		non-adherent mesh infused			infection control practices rela	ted	
	with healing ointme	ent). LPN 10 wiped off the Triad			to correct placement of cathet	er	
		pad, applied the Xeroform			bags and infection control rela	ited	
	_	bed, applied a border			to hand hygiene with wound c	are	
	_	her gloves, washed her hands,			2x/week x4 weeks, weekly x4		
	and donned clean g	loves to treat the next wound.			weeks, and monthly x6 month		
					How the corrective action(s) w		
		for Resident 2 was reviewed on			monitored to ensure the defici		
		A.M. A Quarterly Minimum Data			practice will not recur, i.e., wh		
		ent, dated 05/27/25, indicated			quality assurance program wil	l be	
		verely cognitively impaired.			put into place?		
	The resident's diagnoses included, but were not				1. For quality assurance, the [
		ypertension, and neurogenic			or ADNS will review any findin	ıgs	
	bladder.			during clinical meeting			
					subsequent correction action	and	
		an's order for the resident's			education for identified staff		
		outtock indicated the wound			members.		
		with Hibiclens, rinsed			2. Findings will be reported at		
		dry, Xeroform gauze applied to			QA meeting monthly x 6 mont		
		covered with a border foam			or until substantial compliance)	
	dressing.				has been determined.	-4	
	The I DN feiled to	shanga thair alayes after			Date corrections will be compl	etea	
		change their gloves after ated objects and failed the			by: June 29th 2025		
	_	oroughly after using the					
	Hibiclens cleansing						
	Thorciens cleansing	gagont.					
	During an interview	v on 06/11/25 at 3:26 P.M., RN 4					1
		viding wound treatments, once					
		s you should not touch					
	, , ,	ir waist, including door knobs,					
		ockets, or anything dirty that					
	had not been cleaned immediately prior. Staff should wash their hands and change gloves if						
	they come into contact with a possibly						
	contaminated item.						
	The current "Handy	washing-Hand Hygiene"					
	policy, with an effective date of 03/01/25, was provided by the Director of Nursing (DON) on						

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HX2O11 Facility ID: 010996

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING							
	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 TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				
TAG	06/12/25 at 10:26 A hands are not visibl hand rubfor all the direct contact with a objectsin the immersident" 2. Resident 100 was room on 06/10/25 at indwelling urinary of hanging under her visible floor. The resident's a mechanical lift was on 06/10/25 at 1:33 propelling themselv wheelchair. Her indwas dragging on the member assisted the down the D-Hall, do offices, and to the A activity. The sound was audible. On 06/10/25 at 2:05 observed pushing the line way to the A bottom of the indwed dragging on the floor was flipped back as The clinical record on 06/10/25 at 2:46 assessment indicate	a.M. The policy indicated, "If the soiled, use an alcohol-based the following situations After the residents After contact with rediate vicinity of the sobserved in the A-Hall dining the soling used to transfer her with the resident was resident was resident was resident was resident by pushing her resident by pushing her resident by pushing her rown the hallway with the staff A-Hall dining room to an of the bag dragging the floor. S. P.M., a staff member was the resident down the A-Hall dining room with the resident down the A-Hall dining room with the resident the resident to the resident to the resident the resident to the resident the resident to the resident was admitted to the resident situations.	IAG		DATE				
	acute neurological of During an interview	not limited to, diabetes and disorder. and observation, on 06/10/25 brate Clinical Support, while							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	00	COMPLETED 06/12/2025			
155665		B. WI	ING		06/12/	2025			
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET 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 APPROPRIA	ATF.	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE		
	_	ent in the A-Hall dining room,							
	indicated no part of an indwelling urinary catheter								
	should be touching	the floor.							
	3. On 06/10/25 at 1	:51 P.M., Resident 101 was in							
		His bed was in a low position							
		thes of his indwelling urinary							
		rectly touching the floor. No							
		etween the catheter bag and							
	the bare floor.								
	_	y and observation on 06/10/25							
	at 3:04 P.M., Qualified Medication Aide (QMA) 8								
		nt was a complete assist with							
	I -	g urinary catheter bag should floor without a barrier							
	1	nd the bag. The bag had two							
		etly touching the floor.							
		out to defining the free!							
	The clinical record	was reviewed on 06/10/25 at							
	2:41 P.M. An Admi	ission MDS assessment, dated							
		the resident was rarely/never							
		sident's diagnoses included,							
		l to, stroke and benign							
		a. The resident had not had a							
	· ·	on (UTI) in the last 30 days.4. ion, on 06/11/25 at 9:10 A.M.,							
	_	ting in her recliner in her room.							
		ary catheter bag was hooked to							
	_	chair with approximately one							
		ing on the bare floor.							
		ion, on 06/11/25 at 11:02 A.M.,							
		ting in her recliner in her room.							
		ary catheter bag was hooked to							
		chair with approximately one							
	inch of the bag resti	ing on the bare floor.							
	During an observati	ion, on 06/11/25 at 2:12 P.M.,							
		ting in her recliner in her room.							

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		X1) PROVIDER/SUPPLIER/CLIA	1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL			
		155665	B. WING 06/12/2025						
NAME OF P	PROVIDER OR SUPPLIER	\			DDRESS, CITY, STATE, ZIP COD				
MAJEST	IC CARE OF NORT	TH VERNON		701 HENRY STREET NORTH VERNON, IN 47265					
							(Vf)		
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
		ary catheter bag was hooked to							
	the right side if the	chair with approximately one							
	inch of the bag resti	ing on the bare floor.							
	During an observati	ion and interview, on 06/11/25							
	-	ent 15 was sitting in her recliner							
		dwelling urinary catheter bag							
	was hooked to the r	ight side if the chair with							
		inch of the bag resting on the							
		ndicated the resident's catheter							
	bag should not have been lying on floor. She moved the urinary catheter bag and hung it on the								
	bed frame.	catheter bag and hung it on the							
	oca mame.								
	The clinical record	for Resident 15 was reviewed							
		0 A.M. A Quarterly MDS							
		3/06/25, indicated the resident							
		act. The resident's diagnoses							
		not limited to, diabetes, ogenic bladder, and aphasia.							
		indwelling urinary catheter.							
	1110 100100110 1100 011	and worting drinking controls							
		policy, titled "Indwelling							
		/02/24, was provided by the							
	_	on 06/12/25 at 1:32 P.M. The							
		if an indwelling catheter is in provide appropriate care for							
	-	rdance with current							
	professional standar								
	2.1.10(1)								
	3.1-18(b)								
	3.1-18(1)								
F 9999									
DI CO									
Bldg. 00	3.1-14 PERSONNE	71	E 0000		E0000		06/20/2025		
	_	ff must be licensed, certified, or	F 9999	'	F9999 What corrective action(s) wil		06/29/2025		
	* *	lance with applicable state			be accomplished for those	•			
	laws or rules.	11			residents who found to have				

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938						
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED			
		155665	B. WI	NG		06/12	/2025		
				STREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF	NAME OF PROVIDER OR SUPPLIER				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	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
					been affected by the deficien	nt			
	This rule is not met	as evidence by:			practice?				
					1 The Staff member was	able			
	The employee recor	rds were provided by the			to take action and have her				
	Human Resources ((HR) Director on 06/10/25 at			certification reinstated				
	2:00 P.M. Certified	Nurse Aide (CNA) 14 was hired			immediately upon identification	n of			
	to the facility on 05	5/06/25.			the lapse.				
					How other residents having t	the			
	During an observat	ion of the employee license			potential to be affected by th				
	book on 06/10/25 a	at 3:15 P.M., CNA 14's license			same deficient practice will be				
	was noted to be exp	pired on 05/07/25.			identified and what correctiv				
	•				actions will be taken.				
	CNA 14 had worked on the following dates in				1 No other residents were	<u> </u>			
	May and June 2025				affected by the deficient practi				
					What measures will be put in				
	- On 05/09/25,				place and what systemic				
	- On 05/16/25,				changes will be made to				
	- On 05/18/25,				ensure that the deficient				
	- On 05/19/25,				practice does not recur?				
	- On 05/21/25,				1 A full audit was complet	ted			
	- On 05/22/25,				of all licensed and certified sta				
	- On 05/23/25,				with no other findings of lapse				
	- On 05/26/25,				certificates or licenses.	-			
	- On 05/27/25,				2 Our online tracking tool	was			
	- On 05/30/25,				updated to ensure that all curr				
	- On 06/01/25,				staff licenses and certification				
	- On 06/02/25,				entered correctly to ensure that				
	- On 06/04/25,				staff and management are not				
	- On 06/06/25,				prior to the expiration. All new				
	- On 06/09/25, and				hires will be updated in the				
	- On 06/10/25.				system to include any license	or			
					certifications with the renewal				
	During an interview	v, on 06/12/25 at 9:30 A.M., the			date. This will update the faci	lity			
		g (DON) and HR Director			HR Director to ensure that all	y			
	1	s license was expired and she			licenses remain up to date and	d in			
	was renewing it at t	-			compliance.	G 111			
	, as renewing it at t	mar mile.			How the corrective action(s)				
	During an interview	v on 06/12/25 at 2:27 P.M. the			will be monitored to ensure t				
	During an interview, on 06/12/25 at 2:27 P.M., the				I will be illumbed to empure t		I		

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with an expired license.

DON indicated CNA 14 should not have worked

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deficient practice will not

recur, i.e., what quality

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

PRINTED: 06/30/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	ĺ	ILDING	ONSTRUCTION 00	(X3) DATE : COMPL 06/12/	ETED
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	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	The current facility policy titled, "Background Check & License Verification", with an effective date of 12/01/2024, and was provided by the Administrator on 06/12/25 at 11:07 A.M. The policy indicated, "To conductlicense verificationsFor all applicants applying for a position as a certified nurse aide, the human resources department will contact the nurse aide registry of the state in which the individual is certifiedto verify that the applicant's certification is in good standing"				assurance program will be purinto place? 1 For quality assurance, the facility Administrator or HR Director will monitor all current future staff licenses to ensure all are kept up to date. 2 Findings will be reported the QA meeting monthly x6 months and will continue until 100% compliance is achieved. Date corrections will be completely: June 29th 2025	he t and that d at	

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