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	03/17/2023

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 the Investigation of Complaints IN00403474, IN00400900, IN00400692, IN00400655, IN00398221, and IN00396246. Complaint IN00403474 - No deficiencies related to the allegation is cited. Complaint IN00400900 - No deficiencies related to the allegation is cited. Complaint IN00400692 - No deficiencies related to the allegation is cited. Complaint IN00400655 - Federal/State deficiency related to the allegation is cited at F686. Complaint IN00398221 - No deficiencies related to the allegation is cited. Complaint IN00396246 - No deficiencies related to the allegation is cited. Unrelated deficiencies are cited. Survey dates: March 13, 14, 15, 16, and 17, 2023 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 3 Medicaid: 84 Other: 15 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	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 04/03/2023. 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandi Paul	Regional Nurse Consultant	03/30/2023

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	03/17/2023

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
	Quality review completed on March 23, 2023.			
F 0686 SS=D 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 provide wound care using the appropriate infection control guidelines related to hand hygiene during wound treatments for 1 of 3 residents reviewed for wounds. (Resident F) Findings include: The clinical record for Resident F was reviewed on 3/13/23 at 3:33 p.m. The diagnoses included, but were not limited to, peripheral vascular disease, dementia, and heart disease. A Significant Change MDS (Minimum Data Set) assessment, dated 12/19/22, indicated the resident was severely cognitively impaired. She required extensive assistance of two or more staff for	F 0686	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident F was identified at the time of observation and continues to reside at the facility. Resident does not have any negative outcomes related to the deficient practice identified. 2. RN 2 re-educated on clean dressing change policy and received written corrective action. 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 requiring wound	04/03/2023

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	03/17/2023

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
	mobility, transfer, and ADLs (Activities of Daily Living). During an observation and interview on 3/14/23 at 9:58 a.m., RN (Registered Nurse) 2 indicated she was getting ready to provide a wound treatment for Resident F. She reviewed the order, and gathered the following supplies: Opti foam 4x4, skintegrity hydrogel (wound healing gel), sure prep, abdominal (ABD) pad, rolled gauze, and normal saline. She did not wash her hands or apply hand sanitizer, entered the room, and observed the resident's legs hanging off the bed. Resident F indicated she needed to use the bathroom. The RN donned gloves with no hand hygiene observed; placed the wheelchair next to the bed; placed her gloved hands under the resident's arm pits and assisted her to stand, pivot, and sit in the wheelchair. The RN wheeled the resident to the bathroom, assisted her to transfer to the toilet. When the resident was finished, the RN had the resident to stand holding onto the handrail, and cleansed her from front to back. RN 2 indicated she needed to change her gloves; she doffed the gloves and donned a clean pair. She did not wash her hands or use hand sanitizer. She removed a 4x4 gauze from the package, used a saline rinse to wet the gauze, used the wet gauze to wipe the sacral area, and indicated the area was healed. RN 2 applied skin prep to the sacral area, and placed a 4x4 foam pad over the area, indicating it was for preventative measures. She assisted the resident to sit in the wheelchair and returned the resident to the room. Resident F asked if the nurse would look for her wide toothed comb, so the RN looked through the bedside dresser drawers for the comb, picked up and showed her a blue brush, a black brush, a white brush, and a small black comb. The resident indicated none were the wide tooth comb she was		treatments have the potential to be affected. 2. A campus wide skin sweep was conducted on 3/28/23 by the DNS with no new wounds/areas of skin impairment identified. 3. All licensed staff educated on Clean Dressing Change policy and Handwashing policy by the IPSD on 3/29/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DHS or Designee will complete an audit using the wound care evaluation checklist during clean dressing change, to include all shifts, 2x/week x4 weeks, weekly x4 weeks, then monthly x6 months. This plan will be revised as warranted. 2. IPSD or Designee will perform random handwashing observations, to include all shifts, utilizing the hand hygiene validation checklist 2x/week x4 weeks, weekly x4 weeks, then monthly x6 months. This plan will be revised as warranted. 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 DHS or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for	

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	03/17/2023

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
	looking for. The RN then doffed her gloves and donned clean gloves; no hand hygiene was observed. RN 2 then removed a yellow gripper sock from the resident's left foot, removed an old heel dressing noting a small amount of drainage. She doffed both gloves, donned clean gloves, and observed the heel was scabbed over. The resident had a dime size wound on her left heel. The RN placed hydrogel on a gloved finger and applied it to the heel, she picked up the rolled gauze off the floor and placed it on the bedside table, applied an ABD pad on the heel, retrieved and opened the rolled gauze and wrapped the heel. RN 2 doffed the right-hand glove, removed tape and a marker from her scrub pocket, dated the tape, placed the tape on the gauze to secure it in place. The RN placed the gripper sock, doffed the left glove, gathered the trash, picked up the call light from the floor and clipped it to the resident's gown. The RN then went to the bathroom and washed her hands, used her right hand to turn off the water, pulled three paper towels, and dried her hands. During an interview on 3/14/23 at 10:19 a.m., RN 2 indicated she should have performed hand hygiene before and after a dressing change. She had not performed hand hygiene after toileting the resident or after removing her old dressing during the dressing change. During an interview on 3/16/23 at 11:30 a.m., the DON (Director of Nursing) indicated she was aware of the Agency RN's failure to wash her hands during a dressing change. The current facility policy titled "Dressings, Dry/Clean " and with a revised date of 2/2018, was provided by the DON on 3/16/23 at 11:30 a.m. The Policy indicated, " ...to provide guidelines for the application of dry, clean dressings ...Steps in the		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 04/03/2023. 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	03/17/2023

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
	Procedure ...1. Establish a clean field. 2. Arrange the supplies so they can be easily reached ...7. Wash and dry hands ...10. Wash and dry hands ...20. Wash and dry hands ...24. Wash and dry hands ..." This Federal tag relates to Complaint IN00400655. 3.1-40 (1)			