PRINTED: 09/24/2024
FORM APPROVED

ES X1) PRO	VIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION			
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ON BIRDE HOLL	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED		
1556	65	B. WING		09/04/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON			STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265			
ARY STATEM	ENT OF DEFICIENCIE	ID	PROVIDENCE N. I.V. OF CORRECTION	(X5)		
ICIENCY MUS'	F BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE			
		TAG	DEFICIENCY)	DATE		
on one of the control	o deficiencies related to and 4, 2024. tate Findings cited in 6.2-3.1.	F 0000	Survey Event ID: OW8911 Cycle Start Date: 9/4/24 F609 – Reporting of Alleged Violations What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? Resident C was identified during the time of observation. The DNS and ED were educated on reporting all alleged violation 9/3/24. 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 have the potential to be affected by the deficient practice. Incident reported to ISDOH 9/3/24. No further corrective action was needed. What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not reconstitute the deficient	onts y the definition ges e ur? n on ill be ent		
N(I) N N N N N N N N N N N N N N N N N N N	Interpolation of the Investors of the In	INORTH VERNON IMARY STATEMENT OF DEFICIENCIE EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION IS for the Investigation of Complaint IN 100439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited. In 1009439556 - No deficiencies related to a recited.	Type: 155665 B. WING PPPLIER NORTH VERNON IMARY STATEMENT OF DEFICIENCIE EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION IS for the Investigation of Complaint N00439556 - No deficiencies related to a recited. SE September 3 and 4, 2024. Iber: 010996 Inber: 155665 INDER: 155665 INDER: 1779e: Output Type: Output Type	STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON IMARY STATEMENT OF DEFICIENCIE EFFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION IS for the Investigation of Complaint		

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

(X6) DATE

TITLE

Katie Mollenhoff 09/17/2024

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.

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

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/04/2024	
	ROVIDER OR SUPPLIE		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	BE PRECEDED BY FULL PREFIX (EACH CORECTIVE ACTION SECRETARY OF COMMENT OF CROSS-REFERENCED TO THE A			
TAG	REGULATORY	K ESC IDENTILITING INFORMATION		quality assurance program put into place? 1 For quality assurance DNS or Designee will revialleged incidents 5 days a during clinical meeting x6 Findings will be reported meeting monthly x6 month will continue until 100% compliance is achieved.	ce, the iew any a week 6 months. at the QA	
				F610 – Investigate/Prevent/Corr Alleged Violation What corrective action(s) accomplished for those re found to have been affect deficient practice? 2 1. Resident C was in during the time of observation by and ED were educated investigation 9/3/24. How other residents having potential to be affected by same deficient practice with identified and what correct action(s) will be taken? 1. All Residents have the potential to be affected by the a	will be esidents ted by the dentified ation. The ted on the y the yill be etion	

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CENTERS FOR	OF HEALTH AND HU! MEDICARE & MEDIC		(Y2) MI	II TIDI E CO	ONSTRUCTION		RM APP	
	OF CORRECTION	IDENTIFICATION NUMBER 155665	l í	JILDING	00	COMPL 09/04/	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 PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMP	(X5) PLETION ATE
					practice. 2. DNS or Designee will educa all management staff on Abus Education and Resident Right policy and proper steps of an investigation of alleged violation by 9/17/24. What measures will be put into	e s ons		

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

1. For quality assurance, the DNS

place and what systemic changes will be made to ensure that the deficient practice does not recur?

1 DNS or Designee will perform audits of alleged violations as they occur to ensure an investigation was completed per policy. This plan will be revised as warranted.

or Designee will review any findings 5 days a week during clinical meeting x6 months.

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

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CENTERS FOR	MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/04/2024	
	PROVIDER OR SUPPLIED		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 0609 SS=D	483.12(b)(5)(i)(A)			regulation. This provider respectfully requests that State Report Platof Correction be considered to Letter of Credible Allegation. This provider alleges compliance as of September 18, 2024. 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.	is	
Bldg. 00	failed to report an a timely manner for reporting of alleged. Findings include: During an interview Resident C indicate facility had called I unsure of their name reported it. During an anonymous op/03/24 and 09/04/08/29/24, LPN (Lievery rude to Reside The LPN was yelling of the nurse's stational reports of the stati	and record review, the facility allegation of verbal abuse in a 1 of 3 residents reviewed for diviolations. (Resident C) w on 09/04/24 at 8:38 A.M., and that a girl that worked at the mim a B**** last week. He was no but believed other staff had hous staff interview, between 1/24, Staff 102 indicated that on censed Practical Nurse) 3 was cent C and was verbally abusive. Ing at the resident over the top on. It was reported to the DON.	F 0609	F609 – Reporting of Alleged Violations What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? Resident C was identified during the time of observation. The DNS and ED were educated on reporting all alleged violation on 9/3/24. 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 have the potential to be affected by the deficient practice. Incident reported to ISDOH 9/3/24. No	nts the ted ns	

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During an anonymous staff interview, between 09/03/24 and 09/04/24, Staff 103 indicated that on

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further corrective action was

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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 09/04/2024 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 COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 08/29/24, LPN 4 was cussing/yelling at Resident C needed. and pointing her finger at him over the top of the nurse's station. The resident told her that she was What measures will be put into upsetting him. She started to walk away from the place and what systemic changes resident and said, "Someone better get him the will be made to ensure that the F*** away from me because the B*** nurse in me deficient practice does not recur? is about to come out." The DON was notified of DNS and ED educated on the situation. reporting all alleged violations on 9/3/24. During an interview on 09/04/24 at 9:04 A.M., the DON indicated it was reported to her that there How the corrective action(s) will be was a situation with Resident C and LPN 4. She monitored to ensure the deficient was told that LPN was verbally abusive to practice will not recur, i.e., what Resident C on 08/29/24. She had called the quality assurance program will be Executive Director and started an investigation put into place? immediately. It was determined that abuse had not For quality assurance, the occurred, and the nurse was able to finish her DNS or Designee will review any shift that night. She had asked the Executive alleged incidents 5 days a week Director if the nurse needed to be removed from during clinical meeting x6 months. the floor, and the ED deemed that the nurse was stern with the resident. She was trying to get him Findings will be reported at the QA to turn his radio down due to over stimulation. meeting monthly x6 months and She had talked with Resident C the next morning will continue until 100% after the incident and he had no concerns and was compliance is achieved. his usual self. After talking with the new Executive Director and Clinical Support Nurse it The creation and submission of was determined that the allegation needed to be this Plan of Correction does not reported. The incident was reported to the Indiana constitute an admission by this Department of Health on 09/03/24. provider of any conclusion set forth in the statement of During an interview on 09/04/24 at 9:59 A.M., the deficiencies, or any violation of DON indicated she did not come into the building regulation. the night of the incident on 08/29/24. She did This provider respectfully everything via phone. She had talked with the requests that State Report Plan resident the following day. of Correction be considered the Letter of Credible Allegation. The investigation report for the, 8/29/24, This provider alleges allegation between Resident C and LPN 4 was compliance as of September reviewed. The investigation lacked an interview 18, 2024.

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with Resident C or any other residents in the

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The facility respectfully

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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 00 COMPLETED 155665 B. WING 09/04/2024 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 facility. requests a desk review for this Plan of Correction relative to The current facility policy titled, "ABUSE, the low scope and severity of MISTREATMENT, NEGLECT, EXPLOITATION, this survey in lieu of a AND MISAPPROPRIATION", dated 01/02/24, post-survey revisit. was provided by the Regional Clinical Support on 09/04/24 at 2:04 P.M. The policy indicated, "...It is the facilities policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident...Initial Report ...Timing ...Department of Health. If abuse is alleged ... If any form of abuse is alleged (e.g., physical, verbal, etc.) ... related to any other reportable incident. The Administrator or his/her designee will notify the Department of Health immediately, but no later than 2 hours after the allegation is made ..." 3.1-28(c)F 0610 483.12(c)(2)-(4) SS=D Investigate/Prevent/Correct Alleged Violation Bldg. 00 Based on interview and record review, the facility F 0610 What corrective action(s) will be 09/18/2024 failed to appropriately investigate an allegation of accomplished for those residents abuse for 1 of 3 residents reviewed for abuse. found to have been affected by the deficient practice? (Resident C) 1. Resident C was identified Findings include: during the time of observation. The DNS and ED were educated on During an interview on 09/03/24 at 10:01 A.M., investigation 9/3/24. CNA (Certified Nurse Aide) 2 indicated she had

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heard that a nurse had gotten into a resident's

face last Thursday, 08/29/24. She wasn't working

at the time of the incident but had heard about it.

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How other residents having the

potential to be affected by the

same deficient practice will be

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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	00	COMPLETED	
		155665	B. WING		09/04/2024	
				ADDRESS CITY OF THE STREET	_	
NAME OF P	ROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
MA IFOT		TH MEDNON		NRY STREET		
IVIAJEST	IC CARE OF NORT	I NEKINON	NORTE	H VERNON, IN 47265		
(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	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		one had reported it to the DON		identified and what correction		
	(Director of Nursin	g).		action(s) will be taken?		
				All Residents have the		
	-	ous staff interview, between		potential to be affected by this	•	
		/24, Staff 102 indicated that on		practice.		
		eensed Practical Nurse) 3 was		2. DNS or Designee will educa		
		ent C and was verbally abusive.		all management staff on Abus		
		d at the top of her lungs that no		Education and Resident Right	s	
		n to his F***ing music. She		policy and proper steps of an		
		esident over the top of the		investigation of alleged violation	ons	
		nurse had turned away from		by 9/17/24.		
		d, "You better get him the				
	F*** away from m	e." It was reported to the DON.		What measures will be put into		
				place and what systemic char	•	
	-	ous staff interview, between		will be made to ensure that the		
		/24, Staff 103 indicated that on		deficient practice does not rec		
		as cussing/yelling at Resident C		1 DNS or Designee will perfo		
		nger at him over the top of the		audits of alleged violations as	-	
		was telling him to shut up and		occur to ensure an investigation		
		to listen to his stupid music.		was completed per policy. This		
		ed away from the resident and		plan will be revised as warran	ted.	
		d something. The nurse turned			20.1	
		at the resident had said, and no		How the corrective action(s) w		
		ner, so the nurse asked the		monitored to ensure the defici		
		d said. The resident told her		practice will not recur, i.e., wh		
	_	ing him. She started to walk		quality assurance program wil	i pe	
		dent and said, "Someone better		put into place?	ONIC	
	-	way from me because the B*** It to come out." The LPN		1. For quality assurance, the [פאוע	
		way and the resident remained		or Designee will review any		
				findings 5 days a week during		
	where he was crying and upset. The DON was			clinical meeting x6 months.		
	notified of the situation. During an anonymous staff interview, between 09/03/24 and 09/04/24, Staff 104 indicated that on 08/29/24, there was another resident sitting at the			2. Findings will be reported at	the	
				QA meeting monthly x6 month		
				and will continue until 100%	13	
				compliance is achieved.		
		g very loud. She was yelling		compliance is achieved.		
		ident C had turned the music up				
	•	on her out the other resident's		The creation and submission	n of	
	i rearry roud, to drow	in her out the other restuents	1	I THE CIEATION AND SUDMISSION	101	

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yelling.

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this Plan of Correction does not

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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	JILDING	00	COMPLETE	D
		155665	B. W	NG		09/04/202	24
NAME OF P	ROVIDER OR SUPPLIER	Ł			ADDRESS, CITY, STATE, ZIP COD		
				701 HENRY STREET			
MAJEST	IC CARE OF NORT	H VERNON		NORTH VERNON, IN 47265			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CC	OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	DATE
1110	TEGGETTOTT OF		1		constitute an admission by t		2.112
	During on interview	on 09/04/24 at 8:38 A.M.,			<u> </u>		
	_	d that a girl that worked at the		provider of any conclusion		-	
		im a B**** last week. He was			forth in the statement of		
	-	e but believed other staff had			deficiencies, or any violation	or	
		e but believed other stall had			regulation.		
	reported it.				This provider respectfully		
	Danie :	00/04/24 + 0.04 + 3.5 - 4			requests that State Report Pl		
	_	on 09/04/24 at 9:04 A.M., the			of Correction be considered		
		as reported to her that there			Letter of Credible Allegation.		
		Resident C and LPN 4. She			This provider alleges		
		vas verbally abusive to			compliance as of September		
		9/24. She had called the			18, 2024.		
		and started an investigation			The facility respectfully		
	· ·	determined that abuse had not			requests a desk review for th		
		urse was able to finish her			Plan of Correction relative to		
	_	had asked the Executive			the low scope and severity o	f	
		e needed to be removed from			this survey in lieu of a		
	·	D deemed that the nurse was			post-survey revisit.		
		ent trying to get him to turn his					
		over stimulation. She had					
		t C the next morning after the					
		no concerns and was his					
	usual self.						
	During an interview	on 09/04/24 at 9:59 A.M., the					
	DON indicated she	did not come into the building					
	the night of the inci	dent on 08/29/24. She did					
	everything via phon	ne. She had talked with the					
	resident the followi	ng day. When investigating					
	allegations of abuse	e, she would make sure the					
	resident was safe, a	nd talk with staff and other					
	residents. The aides	had talked with the resident					
	that night, but they did not initiate an						
		s to be done by the Executive					
	•	l Service Director usually					
		esidents but that was not					
	done.						
	The investigation re	eport for the, 8/29/24,					
	_	-					
allegation between Resident C and LPN 4 was							

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>00</u>			COMPLETED		
	155665		B. WING			09/04/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON			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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		stigation lacked an interview					
		any other residents in the					
	facility. The DON is	and talked with 5 staff members.					
	The current facility	policy titled, "ABUSE,					
	-	, NEGLECT, EXPLOITATION,					
		RIATION", dated 01/02/24,					
		Regional Clinical Support on					
		M. The policy indicated, "It is					
		to investigate all alleged					
	violations involving						
	Misappropriation of	-					
		treatment, including Injuries of					
		n accordance with this policy					
		ll individuals who report such					
		tions are free from retaliation					
	or reprisal for repor						
	• •	ion Protocol. The person					
	_	cident should generally take					
		s: Interview the resident, the					
		nessesIf the allegation					
	involves abuse/neglect, interview other residents,						
	as appropriate, to determine if they may have been						
		used staff member or					
	resident"						
	3.1-28(d)						

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