STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING _____ B. WING _____	R 08/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS This was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 29, 2022. This visit was in conjunction with the PSR to the Investigation of Complaint IN00380062 completed on May 23, 2022, and the Investigation of Complaint IN00385898. Complaint IN00385898 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00380062 - Corrected Survey dates: August 1 and 2, 2022 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 14 Medicaid: 71 Other: 22 Total: 107 Majestic Care of North Vernon was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of the PSR to the Recertification and State Licensure Survey. Quality review completed on August 3, 2022.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING _____ B. WING _____	R 08/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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