

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of North Vernon		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Henry Street North Vernon, IN 47265	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0776</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

TITLE

(X6) DATE

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<p>F 0776</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on observation, record review, and interview, the facility failed to meet the needs of a resident related to image acquisition by a contracted x-ray staff member. The resident's arm was improperly positioned and she cried out for 1 of 3 residents reviewed for diagnostic services. The resident's arm resulted with a fracture. (Resident B) Findings include: During an observation, on 10/15/2025 at 9:12 A.M., Resident B was lying in bed, her eyes were closed. There were no signs of distress. The resident had a red cast on her right arm that went from her hand up past her elbow. The clinical record for Resident B was reviewed on 10/15/2025 at 9:23 A.M. An Annual Minimum Data Set (MDS) assessment, dated 08/21/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, hypertension, neurogenic bladder, arthritis, and aphasia. The resident had physical impairments on one side of the upper and lower extremities. A Progress Note, dated 08/27/2025 at 9:49 P.M., indicated the resident was noted to have redness to both elbows, warmth to touch, and complaints of pain. Nurse Practitioner (NP) 5 was notified, and a new order was obtained for the resident to receive doxycycline (an antibiotic), 100 milligrams (mg), twice a day for 7 days for cellulitis. The NP indicated they would be in the facility the next day to assess the resident. A Physician Note, dated 08/28/2025, indicated the resident was seen for bilateral elbow redness. The resident was having more pain on the right side, with difficulty moving the arm. An x-ray would be ordered along with ibuprofen 400 mg, twice a day for two to three days. An X-Ray Result, dated 08/28/2025, indicated the resident had no obvious fractures or dislocation. A Critical Note from the X-Ray Tech, dated 08/28/2025 at 8:50 P.M., indicated the patient was unable to position for exam, the patient (Resident B) screamed if the tech tried to position the arm/elbow. A Physician Note, dated 09/29/2025, indicated the resident was seen for right arm pain in the shoulder and wrist and was described as aching. There was no history of trauma or falls. The resident's Tylenol had been ineffective in managing the pain. A new order was obtained for the resident to receive ibuprofen 400 mg, every six hours as needed for pain management, and to discontinue the Tylenol. A Progress Note, dated 10/01/2025 at 1:00 P.M., indicated the NP was in the facility and ordered an x-ray of the resident's right shoulder. The resident and her family member refused to pursue with an x-ray at that time. A Physician Note, dated 10/02/2025, indicated the resident reported significant pain in her right upper extremity that was exacerbated with passive movement. The pain was not very well controlled presently. The resident's medications would be adjusted, and an x-ray would be ordered of the resident's right forearm. A Physician Note, dated 10/03/2025, indicated the resident's x-ray result showed a fracture and the resident reported that she thought the fracture was from the x-ray technician's (tech) procedure when they had obtained the previous x-ray. An X-Ray Result, dated 10/03/2025, indicated, Resident B had a mildly displaced healing distal diaphyseal fracture of the ulna as well as mildly angulated, mildly displaced, proximal diaphyseal fracture of the radius, two bones in the arm. The age of the injury was labeled as indeterminate. During an interview, on 10/15/2025 at 10:12 A.M., Resident B's family member indicated in August an outside x-ray company had come into the facility and completed an x-ray on the resident's right arm. The resident had a contracture, (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility), on the right arm and was non-verbal. The resident was able to answer yes or no questions but was very hard to understand. A facility nurse, RN 2 had heard the resident scream when the x-ray tech was conducting the x-ray procedure. The RN went into the room and stopped the x-ray because they were turning the resident's right arm in a way that it wouldn't turn due to the resident's contracture. The resident recently started having more pain and another x-ray was completed with a result of a fracture in the right arm. During an interview, on 10/15/2025 at 10:56 A.M., RN 2 indicated in August the resident had redness to her bilateral elbows. The physician ordered x-rays to check for gout and fractures. The x-ray tech had come into the facility to complete the x-ray, and the RN asked the tech if she needed help. The x-ray tech didn't need help, and the RN continued to stay at the nurse's station to chart. While she was charting, she heard the resident crying out loudly. She had never heard the resident yell out like that before, so she went to the room, and she saw the x-ray tech pull the resident's right arm straight out and turn it at the same time. The RN stopped the tech and told her the resident's arm wouldn't move like that because she had a contracture. The tech said she wouldn't be able to get any more images unless the arm was straight. The tech stopped and did not get anymore images after that. The RN had told the Director of Nursing (DON), and the resident was monitored for pain and discomfort. The x-rays at that time had come back without fractures. At the end of September</p>		