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	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of North Vernon	701 Henry Street North Vernon, IN 47265

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 2. During an observation and interview, on 06/08/25 at 10:19 A.M., Resident 37 was sitting on the side of the bed in her room. There were three medication cups sitting on the resident's bedside table. One medication cup contained three small white capsules, the second one contained a large white capsule, and the third one contained a large round pill broke in half, a medium round peach colored pill, one large round pill, one medium round white pill. The resident indicated the medications were hers and the nurse had left them for her to take. No staff members were in or near the resident's room or in the hallway outside the resident's room. The clinical record was reviewed on 06/10/25 at 11:03 A.M. A Quarterly MDS assessment, dated 04/21/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, heart failure, dementia, anxiety, and depression. During an interview, on 06/11/25 at 9:54 A.M., Licensed Practical Nurse (LPN) 3 indicated medications should not have been left at the resident's bedside. A resident should be watched while they take their medications unless they were assessed to self-administer. During an interview, on 06/11/25 at 11:17 A.M., the DON indicated the resident did not have a self-administration assessment. She was not safe to self-administer any of her medications. The current facility policy titled, Medication Administration, dated 01/02/2024, was provided by the DON on 06/11/25 at 11:40 A.M. The policy indicated, .23. Unless the resident has been assessed for safe self-administration of medications, medications are not to be left unattended for the resident to consume at a later time. The MEDICATION SELF-ADMINISTRATION SAFETY SCREEN records for the last six months for Resident 78 were provided by the Director of Nursing (DON) on 06/11/25 11:15 A.M. There was only one record for this resident. The record, with an effective date of 04/02/25, indicated the resident required assistance with medication administration and the Resident may NOT self-administer medications. Ongoing assessment should occur at a minimum of quarterly. 3.1-11(a) Based on observation, interview, and record review, the facility failed to ensure residents were deemed appropriate to self-administer medications prior to leaving medications at the residents bedside unsupervised for 2 of 2 residents reviewed for self-administering medications. (Residents 78 and 37) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: 1. During an observation and interview, on 06/10/25 at 11:49 A.M., Resident 78 was reclining on her bed in her room. A medication cup was sitting on the resident's over the bed table. The medication cup contained one half of a round white tablet and one small red and white capsule. The resident indicated the medications were Lyrica (a pain medication) and her anxiety pill. She did not know the name of her anxiety pill. Sometimes the staff left them at the bedside and sometimes they stood at the bedside and watched her take them. If the staff member knew her, they would leave them at the bedside. If they did not know her, they would stand there and watch her take them. No staff members were in or near the immediate area of the resident's room. Other residents were independently mobile and propelling themselves down the hallway. The clinical record was reviewed on 06/11/25 at 10:05 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/05/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stoke, anxiety, depression, and respiratory failure. During an interview, on 06/11/25 at 11:40 A.M., the DON indicated there were no residents currently in the building who self-administered their medications.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise a resident's care plan related to prophylactic antibiotic usage for 1 of 21 residents reviewed for care plans. (Resident 58) Findings include: Resident 58's clinical record was reviewed on 06/11/25 at 3:24 P.M. A Quarterly Minimum Data Set assessment, dated 02/28/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, diabetes, and renal insufficiency. The resident had an indwelling urinary catheter. The resident's current physician's orders included, but were not limited to the following: - An open-ended physician's order, with a start date of 02/13/25, for Cephalexin (an antibiotic) 500 milligrams, once daily for prophylaxis for recurrent UTIs (Urinary Tract Infections). The resident's Electronic Medication Administration Records for February, March, April, May, and June 2025 indicated the resident received the antibiotic daily since 02/13/25. The resident's complete Care Plan Report was reviewed on 06/12/25 at 10:45 A.M. and lacked a care plan for the prophylactic antibiotic usage. During an interview, on 06/12/25 at 11:05 A.M., the Director of Nursing indicated the resident's family reported the resident had a history of UTIs. The resident's urologist ordered the prophylactic antibiotic. The facility called to see about discontinuing the antibiotic, but the urologist wanted the resident to continue to receive the medication daily. The resident's care plan should have been updated to indicate she was receiving the prophylactic antibiotic. The current facility policy, titled Comprehensive Care Plan, dated 11/01/24, was provided by the Director of Nursing on 06/12/25 at 1:42 P.M. The policy indicated, .The comprehensive care plan will describe, at a minimum .services .to maintain the resident's/patient's highest practicable physical, mental, and psychosocial well-being . 3.1-35(b)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for cardiac medications for 3 of 21 residents reviewed for quality of care. (Residents 58, 15, and 7) Findings include: 1. Resident 58's clinical record was reviewed on 06/11/25 at 3:24 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/28/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hypertension, and coronary artery disease. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 01/11/25, for Midodrine 10 milligram (mg) tablet, three times a day. The resident was to receive one tablet by mouth, at 8:00 A.M., 12:00 P.M., and 8:00 P.M., for hypotension. The medication was to be held if the resident's systolic blood pressure (top number) was greater than 120. The Electronic Medication Administration Record (EMAR) for May 2025 indicated the resident received the medication when the systolic blood pressure was over 120 on the following dates and times: - On 05/02/25 at 12:00 P.M., when the blood pressure was 136/80, - On 05/03/25 at 8:00 P.M., when the blood pressure was 140/63, - On 05/05/25 at 12:00 P.M., when the blood pressure was 122/64, - On 05/06/25 at 12:00 P.M., when the blood pressure was 124/74, - On 05/08/25 at 12:00 P.M., when the blood pressure was 128/74, - On 05/11/25 at 8:00 A.M., when the blood pressure was 128/72, at 12:00 P.M., when the blood pressure was 132/70, and at 8:00 P.M., when the blood pressure was 124/78, - On 05/12/25 at 8:00 A.M., when the blood pressure was 128/74, and at 12:00 P.M., when the blood pressure was 124/72, - On 05/16/25 at 8:00 P.M., when the blood pressure was 128/68, - On 05/20/25 at 12:00 P.M., when the blood pressure was 126/70, and at 8:00 P.M., when the blood pressure was 123/67, - On 05/21/25 at 8:00 A.M., when the blood pressure was 136/68, at 12:00 P.M., when the blood pressure was 124/72, and at 8:00 P.M., when the blood pressure was 129/68, - On 05/24/25 at 12:00 P.M., when the blood pressure was 123/63, and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 05/29/25 at 8:00 A.M., when the blood pressure was 128/70, at 8:00 P.M., when the blood pressure was 133/69. 2. The clinical record for Resident 15 was reviewed on 06/10/25 at 10:30 A.M. A Quarterly MDS assessment, dated 03/06/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, hypertension, neurogenic bladder, and aphasia. The resident had an indwelling urinary catheter. An open-ended physician's order, with start date of 12/11/24, indicated the resident was to receive Losartan (a blood pressure medication) 50 mg, once a day for hypertension. The staff were to hold the medication if the systolic blood pressure was less than 120 or the heart rate was less than 60. The March, April, May, and June 2025 EMAR indicated the resident received the medication when their systolic blood pressure was less than 120 on the following dates: - On 03/06/25 when the blood pressure was 108/61, - On 03/11/25 when the blood pressure was 97/55, - On 03/19/25 when the blood pressure was 91/50, - On 04/01/25 when the blood pressure was 101/62, - On 04/03/25 when the blood pressure was 107/65, - On 04/06/25 when the blood pressure was 101/65, - On 04/10/25 when the blood pressure was 106/68, - On 04/23/25 when the blood pressure was 108/60, - On 04/30/25 when the blood pressure was 108/60, - On 05/01/25 when the blood pressure was 109/66, - On 05/21/25 when the blood pressure was 93/59, - On 06/04/25 when the blood pressure was 108/63, and - On 06/06/25 when the blood pressure was 103/63. 3. The clinical record for Resident 7 was reviewed on 06/10/25 at 02:32 P.M. A Quarterly MDS assessment, dated 05/30/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, amputation, anemia, hypertension, obstructive uropathy, diabetes, seizure disorder, anxiety, and depression. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current, open-ended physician's order, with a start date of 04/07/25, indicated the resident was to receive Midodrine 10 mg, three times a day at 8:00 A.M., 12:00 P.M., and 8:00 P.M. The staff were to hold the medication if the residents systolic blood pressure was greater than 120. The April, May, and June 2025 EMAR indicated the resident had received the medication when their systolic blood pressure was greater than 120 on the following dates and times: - On 04/27/25 at 8:00 A.M., when the blood pressure was 129/51, - On 04/28/25 at 12:00 P.M., when the blood pressure was 136/69 and 8:00 P.M., when the blood pressure was 129/74, - On 05/05/25 at 12:00 P.M., when the blood pressure was 129/47, - On 05/10/25 at 8:00 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 pressure was 134/62 and 12:00 P.M., when the blood pressure was 134/62, - On 05/22/25 at 8:00 P.M., when the blood pressure was 151/63, - On 05/27/25 at 12:00 P.M., when the blood pressure was 136/43, - On 05/29/25 at 8:00 P.M., when the blood pressure was 127/45, - On 06/03/25 at 8:00 A.M., when the blood pressure was 140/60, - On 06/07/25 at 8:00 P.M., when the blood pressure was 122/60, - On 06/09/25 at 12:00 P.M., when the blood pressure was 128/59, and - On 06/10/25 at 12:00 P.M., when the blood pressure was 143/56. During an interview, on 06/11/25 at 11:10 A.M., Licensed Practical Nurse 2 indicated if a resident's medication had hold parameters, she would obtain the vital signs and if they were outside the parameters to give the medication then she would not administer it to the resident. She would document in the EMAR that the medication was not administered due to it being outside the parameters. The current facility policy titled, Medication Administration was dated 01/02/2024, was provided by the Director of Nursing on 06/11/25 at 11:40 A.M. The policy indicated, .Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters . 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure proper placement of a urinary catheter drainage bag for a resident that received prophylactic antibiotics for Urinary Tract Infections (UTIs) for 1 of 4 residents reviewed for indwelling urinary catheters. (Resident 58) Findings include: On 06/09/25 at 10:28 A.M., Resident 58 was observed in her room in bed. The resident's urinary catheter drainage bag was hanging on the side of her bed. Dark yellow urine with sediment was visible in the tubing. There was a mat on the floor next to the bed and the bed was in a lower position. About two inches of the drainage bag was resting on the bare floor in the space between the bed and the floor mat. Resident 58 was observed in the A-Hall dining room on 06/10/25 at 12:12 P.M. The resident's catheter drainage bag was hanging under her wheelchair, with about an inch of the drainage bag resting on the floor. Resident 58's clinical record was reviewed on 06/11/25 at 3:24 P.M. A Quarterly Minimum Data Set assessment, dated 02/28/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, diabetes, and renal insufficiency. The resident had an indwelling urinary catheter. The resident physician's orders included, but were not limited to the following: - An open-ended physician's order, with a start date of 02/13/25, for Cephalexin (an antibiotic) 500 milligrams, once daily for prophylaxis for recurrent UTIs. The resident recieved the medication every day as ordered. During an interview, on 06/10/25 at 2:57 P.M., the Corporate Clinical Support Nurse indicated no part of an indwelling urinary catheter should be touching the floor. The current facility policy, titled Indwelling Catheter, dated 01/02/24, was provided by the Director of Nursing on 06/12/25 at 1:32 P.M. The policy indicated, .if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice . 3.1-41(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to follow physician's orders related to medication administartion for 1 of 21 residents reviewed for pharamcy services. (Resident 23) Findings include: During an observation, on 06/09/25 at 8:48 A.M., RN 4 sanitized her hands and prepared medications for Resident 23. After placing all the medications into a cup that included, but was not limited to, a Potassium Chloride Extended-Release 10 milliequivalent (MEQ) tablet, she poured the medications into a pouch, crushed the medications, placed them back into the medication cup, and added applesauce. The medications were administered to the resident. The current, open-ended physician's order, with a start date of 07/13/23, indicated the resident was to receive Potassium Chloride 10 MEQ Extended-Release tablet, once a day. The staff were to place the medication in applesauce and allow it to dissolve. The tablet was not to be crushed. During an interview, on 06/11/25 at 12:07 P.M., the Director of Nursing (DON) indicated if a physician's order stated to not crush a medication, then it should not have been crushed. The current facility policy titled, Medication Administration was dated 01/02/2024, was provided by the Director of Nursing on 06/11/25 at 11:40 A.M. The policy indicated, .Administer medication as ordered in accordance with manufacturer specifications .Crush medications as ordered. Do not crush medications with do not crush instructions . 3.1-48(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store medications appropriately related to outdated/undated medications for 3 of 4 medication carts observed. (A, B, and C Hall medication Carts) Findings include: The A-Hall Medication Cart was observed on [DATE] at 10:14 A.M., with Licensed Practical Nurse 2. The following was observed: - an unopened vial of insulin Lispro for Resident 59 that was undated, - an opened Symbicort inhaler for Resident 17 that was undated, and - an opened Albuterol inhaler for Resident 17 that was undated. The B-Hall Medication Cart was observed on [DATE] at 10:19 A.M., with LPN 6. The following was observed: - a Combivent inhaler for Resident 65, that was dated [DATE]. The C-Hall Medication Cart was observed on [DATE] at 10:27 A.M., with LPN 3. The following was observed: - an opened vial of Humalog for Resident 16 that was 3/4 full that was undated. The nurse indicated it came from the pharmacy on [DATE] and wrote that as the open date on the vial. During an interview on [DATE] at 11:37 A.M., the Director of Nursing (DON) indicated all insulins should have dates on them if they were in the medication cart. If they were not opened, then they should have been in the refrigerator. The albuterol inhalers were good for one year after they were opened, the Symbicort and Combivent were good for 90 days. The inhalers should have had open dates and should be discarded after they expired. The current Product Expiration Dates with a revision date of [DATE], was provided by the DON on [DATE] at 1:38 P.M. The policy indicated, .Insulin vials .Room Temperature Exp [expiration] date .28 days .Albuterol [aerosol] .12 months .Combivent .3 months .Symbicort .90 days . 3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 2. The D-Hall Dining room meal service was observed on 06/08/25 at 11:51 A.M. Certified Nurse Aide (CNA) 9 pushed a chair in the dining room using her hands, touched her nose with her left hand, sat down in a chair by three residents sitting at the table nearest the kitchen door, touched her face and ear with her right hand, then served a meal tray to Resident 6. CNA 9 touched the resident's plate and napkin, unrolled the napkin, took out the silverware, removed the foil from the resident's baked potato, chopped it up with the resident's fork holding the fork in her right hand, opened the resident's sour cream packet, and squirted the sour cream on the resident's potato. The resident picked up the fork and fed herself. CNA 9 used hand sanitizer then served a tray to another resident. During an interview, on 06/11/25 at 2:11 P.M., CNA 9 indicated when serving meal trays, staff were to use hand sanitizer after each tray and wash their hands after three to five trays. Staff were not to touch themself before serving meal trays. The current Handwashing-Hand Hygiene policy, 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 . 3.1-21(i)(2) 3.1-21(i)(3) Based on observation and interview, the facility failed to follow appropriate guidelines related to the use of hair coverings in the kitchen and store foods in a sanitary manner related to unlabeled and outdated foods and for 1 of 3 kitchen observations, and failed to follow appropriate infection control guidelines related to hand hygiene for 1 of 4 dining observations. (D-Hall Dining Room) Findings include: 1. During the initial tour of the kitchen on 06/08/25 at 10:10 A.M., Activity Aide 12 was observed in the kitchen preparing drinks near the coffee pots. The Activity Aide had a long beard the touched his collar bone that was not contained in a beard net. The kitchen refrigerators were observed on 06/08/25 at 10:12 A.M. and contained the following: - An undated rectangular metal pan covered in plastic wrap that contained tuna salad, - A large, lidded container 3/4 full of Dijon pork. The label indicated the pork was prepared on 06/02/25, and was to be used 06/05/25, - A 1/3rd full gallon of milk, with a best by date of 05/26/25, and - A 1/3 full clear pitcher of tomato juice. The label indicated the juice was made on 06/03/25 and was to be used by 06/06/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 06/08/25 at 10:18 A.M., the Assistant Dietary Manager indicated the Activity Aide's beard should have been covered. The tuna salad should have been labeled with a prepared on date. The pork, milk, and tomato juice were expired and should have been thrown out. The current facility policy, titled Staff Attire, dated 10/2023, was provided by the Administrator on 06/12/25 at 10:26 A.M. The policy indicated, .All staff members will have .facial hair properly restrained . The current facility policy, titled Food Storage: Cold Foods, dated 02/2023, was provided by the Administrator on 06/12/25 at 10:26 A.M. The policy indicated, .All foods will be .labeled and dated .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines during a wound dressing change, and for indwelling urinary catheter management for 4 of 21 residents reviewed for infection control. (Residents 2, 100, 101, and 15) Findings include: 1. A wound dressing change for Resident 2 was observed on 06/10/25 at 10:41 A.M., with Licensed Practical Nurse (LPN) 7 and LPN 10. The LPN's donned gowns in the hallway from a cart of supplies sitting next to the resident's room door. LPN 10 donned gloves. With her gloves on, she reached into her pocket on her scrubs, got her treatment cart keys out, and used them to open the cart. She gathered treatment supplies, took them into the resident's room, laid the supplies on the over bed table, went into the bathroom located in the resident's room, did not turn on the water or change gloves, came out with paper towels, and put the paper towels on the over bed table. LPN 10 opened several gauze pads and made a stack, touching the gauze pads with her gloved hands. The LPNs rolled the resident towards LPN 7, who held the resident on their side. LPN 10 sprayed a wound cleanser, Hibiclens, on a gauze pad from the stack, and wiped the resident's tennis ball sized bleeding wound located on her left buttock. LPN 10 patted the wound with more gauze pads in an attempt to stop the bleeding. She applied a small amount of a protective paste, Triad, when LPN 7 indicated the treatment was supposed to be Xeroform gauze (a non-adherent mesh infused with healing ointment). LPN 10 wiped off the Triad paste with a gauze pad, applied the Xeroform gauze to the wound bed, applied a border dressing, removed her gloves, washed her hands, and donned clean gloves to treat the next wound. The clinical record for Resident 2 was reviewed on 06/11/25 at 10:09 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/27/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hypertension, and neurogenic bladder. The current physician's order for the resident's wound on her left buttock indicated the wound was to be cleansed with Hibiclens, rinsed thoroughly, patted dry, Xeroform gauze applied to the wound bed, and covered with a border foam dressing. The LPN failed to change their gloves after touching contaminated objects and failed the rinse the wound thoroughly after using the Hibiclens cleansing agent. During an interview on 06/11/25 at 3:26 P.M., RN 4 indicated when providing wound treatments, once you don your gloves you should not touch anything below your waist, including door knobs, anything in your pockets, 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 Handwashing-Hand Hygiene policy, with an effective date of 03/01/25, was provided by the Director of Nursing (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 . (continued on next page)

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	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of North Vernon	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 100 was observed in the A-Hall dining room on 06/10/25 at 12:12 P.M. The resident's indwelling urinary catheter drainage bag was hanging under her wheelchair and touching the floor. The resident's sling used to transfer her with a mechanical lift was visible at her shoulders. On 06/10/25 at 1:33 P.M., the resident was propelling themselves down the D-Hall in her wheelchair. Her indwelling urinary catheter bag was dragging on the floor. At 1:35 P.M., a staff member assisted the resident by pushing her down the D-Hall, down the hallway with the staff offices, and to the A-Hall dining room to an activity. The sound of the bag dragging the floor was audible. On 06/10/25 at 2:05 P.M., a staff member was observed pushing the resident down the A-Hall all the way to the A-Hall dining room with the bottom of the indwelling urinary catheter bag dragging on the floor. The blue cover on the bag was flipped back as it was dragging on the floor. The clinical record for Resident 100 was reviewed on 06/10/25 at 2:46 P.M. An Entry MDS assessment indicated the resident was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, diabetes and acute neurological disorder. During an interview and observation, on 06/10/25 at 2:57 P.M., Corporate Clinical Support, while observing the resident 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 bed in their room. His bed was in a low position and two to three inches of his indwelling urinary catheter bag was directly touching the floor. No barrier was noted between the catheter bag and the bare floor. During an interview and observation on 06/10/25 at 3:04 P.M., Qualified Medication Aide (QMA) 8 indicated the resident was a complete assist with care. His indwelling urinary catheter bag should not be touching the floor without a barrier between the floor and the bag. The bag had two to three inches directly touching the floor. The clinical record was reviewed on 06/10/25 at 2:41 P.M. An admission MDS assessment, dated 06/05/25, indicated the resident was rarely/never understood. The resident's diagnoses included, but were not limited to, stroke and benign prostatic hyperplasia. The resident had not had a urinary tract infection (UTI) in the last 30 days. 4. During an observation, on 06/11/25 at 9:10 A.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. During an observation, on 06/11/25 at 11:02 A.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. During an observation, on 06/11/25 at 2:12 P.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. (continued on next page)

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	155665	A. Building B. Wing	06/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview, on 06/11/25 at 2:13 P.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. CNA 5 indicated 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. The clinical record for Resident 15 was reviewed on 06/10/25 at 10:30 A.M. A Quarterly MDS assessment, dated 03/06/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, hypertension, neurogenic bladder, and aphasia. The resident had an indwelling urinary catheter. The current facility policy, titled Indwelling Catheter, dated 01/02/24, was provided by the Director of Nursing on 06/12/25 at 1:32 P.M. The policy indicated, .if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice . 3.1-18(b) 3.1-18(l)