

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

PRINTED: 03/12/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2024
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NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331
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(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
E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 02/22/24</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>At this Emergency Preparedness survey, Majestic Care of Connorsville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 166 certified beds. At the time of the survey, the census was 90.</p> <p>Quality Review completed on 02/26/24</p>	E 0000		
K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 02/22/24</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>At this Life Safety Code survey, Majestic Care of Connorsville was found not in compliance with</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Benjamin Meier	Executive Director	03/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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K 0363 SS=E Bldg. 01	<p>Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2.</p> <p>The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 02/26/24</p> <p>NFPA 101 Corridor - Doors Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p>			

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	<p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 4 residents.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support Representative on 02/22/23 between 12:10 p.m. and 2:50 p.m., Resident Room corridor door #309 in the East Building failed to latch positively</p>	K 0363	<p>Maintenance Director/ Designee will ensure that doors that do not latch into their frame will do so by 03/21/2023.</p> <p>Maintenance Director/ Designee ensured that doors latched positively into their respective frames. This was completed by 03/21/2023</p> <p>On 02/22/2023 the facility administrator educated the maintenance director regarding the regulation that requires doors to latch positively into their respective frames.</p>	03/21/2024

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K 0000 Bldg. 03	<p>into the door frame. The room was being used for storage and was equipped with a keypad style lock requiring numerical input in order to latch.</p> <p>The finding was acknowledged by the Executive Director, Maintenance Director and Regional Facilities Support Representative at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, Regional Facilities Support Representative and Executive Director from another facility all present.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 02/22/24</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>At this Life Safety Code survey, Majestic Care of Connerville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2.</p> <p>The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111)</p>	K 0000	Maintenance Director/ Designee will audit doors weekly x 4 to ensure they latch positively into their respective frames.	

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K 0271 SS=E Bldg. 03	<p>construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 02/26/24</p> <p>NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of over 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 12 residents and staff using the 900 Hall Exit.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support Representative on 02/22/23 between 12:10 p.m. and 2:50 p.m., the exit discharge from the 900 Hall Exit, had approximately a 2 inch change in</p>	K 0271	<p>Maintenance Director/ Designee will ensure that the 900 hall exit leading to the parking lot has a all-weather travel surface leading to a parking lot no later than 03/21/2024</p> <p>Maintenance Director/ Designee has ensured that the 900 hall exit leading the parking lot has an all weather travel surface leading to a parking lot. This was completed by 03/21/2023</p> <p>On 02/22/2023 the facility administrator educated the maintenance director regarding the regulation stating all discharges from exits must have a all weather</p>	03/21/2024

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K 0363 SS=E Bldg. 03	<p>elevation where the landing and the sidewalk meet creating a trip hazard. The Executive Director stated that the facility already had a quote to have this, and another concrete issue corrected.</p> <p>The finding was acknowledged by the Executive Director, Maintenance Director and Regional Facilities Support Representative at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, Regional Facilities Support Representative and Executive Director from another facility all present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that</p>		<p>travel surface leading to a parking lot or public access.</p> <p>Maintenance Director/ Designee will audit the building discharges from exits for all weather travel surface leading to a parking lot or public access point monthly x 3 to ensure discharges from exit are proper. Then as determined by QAA committee.</p>	

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	<p>release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 4 residents.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support Representative on 02/22/23 between 12:10 p.m. and 2:50 p.m., the following corridor doors in the West Building failed to latch positively into their respective door frames:</p> <p>A) The Kitchen Door from the kitchen into the dining area. B) The Activities Office</p> <p>The finding was acknowledged by the Executive</p>	K 0363	<p>Maintenance Director/ Designee will ensure that doors that do not latch into their frame will do so by 03/21/2023.</p> <p>Maintenance Director/ Designee ensured that doors latched positively into their respective frames. This was completed by 03/21/2023</p> <p>On 02/22/2023 the facility administrator educated the maintenance director regarding the regulation that requires doors to latch positively into their respective frames.</p> <p>Maintenance Director/ Designee will audit doors weekly x 4 to ensure they latch positively into their respective frames.</p>	03/21/2024

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	Director, Maintenance Director and Regional Facilities Support Representative at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, Regional Facilities Support Representative and Executive Director from another facility all present. 3.1-19(b)				