

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

PRINTED: 08/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331		
(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	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/14/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 08/27/24</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>At this PSR Life Safety Code survey, Majestic Care of Connersville was found 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) 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 81 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 08/28/24</p>	{K 000}			
{K 000}	INITIAL COMMENTS	{K 000}			

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

TITLE

(X6) DATE

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.

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