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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED
		155491	B. W	B. WING			2022
				CTDEE	TADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD		
MAIFOTI	C CARE OF CONN	IEDOVII I E			E 5TH STREET NERSVILLE, IN 47331		
MAJESTI	C CARE OF CONN	IERSVILLE		CON	NERSVILLE, IN 47331		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000	00						
Bldg							
	An Emergency Prep	paredness Survey was	E 0	000	The creation and submission	n of	
	conducted by the In-	diana Department of Health in			this Plan of Correction does	this Plan of Correction does not	
	accordance with 42	CFR 483.73.			constitute an admission by t	his	
					provider of any conclusion s	et	
	Survey Date: 07/18	//22			forth in the statement of		
					deficiencies, or any violation	of	
	Facility Number: 0	00316			regulation.		
	Provider Number:	155491			/b>		
	AIM Number: 1002	286370					
	At this Emergency I	Preparedness survey, Majestic					
	Care of Connersville	e was found in substantial					
	compliance with En	nergency Preparedness					
	Requirements for M	ledicare and Medicaid					
	Participating Provid	lers and Suppliers, 42 CFR					
	483.73						
	•	certified beds. At the time of					
	the survey, the cens	us was 99.					
	Quality Review con	npleted on 0'//28/22					
E 0039	403 748(d)(2) 416	6.54(d)(2), 418.113(d)(2),					l
SS=C	. , . , .	2.15(d)(2), 483.475(d)(2),					
Bldg		102(d)(2), 485.625(d)(2),					
Diag		727(d)(2), 485.920(d)(2),					
		1.12(d)(2), 494.62(d)(2)					
	EP Testing Requir						
	- , , , , -	18.113(d)(2), §441.184(d)(2),					
		32.15(d)(2), §483.73(d)(2), 184.102(d)(2), §485.68(d)(2),					
	. , , , ,	185.727(d)(2), §485.08(d)(2),					
	(2), §491.12(d)(2),						
	(2), 3431.12(u)(2),	3+34.02(u)(z).					
	*[For ASCs at 8/1	6.54, CORFs at §485.68,					
		o.54, CORPS at §465.66, ons" under §485.727,					
	•	20, RHCs/FQHCs at					
		20, 14103/1 Q1103 at					

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

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E2BG21 Facility ID: 000316 If continuation sheet Page 1 of 63

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING B. WING			COMPLETED 07/18/2022	
		155491	B. WING			07/18/	2022	
NAME OF F	PROVIDER OR SUPPLIER	3			DDRESS, CITY, STATE, ZIP COD			
					5TH STREET			
MAJESTIC CARE OF CONNERSVILLE				CONNE	RSVILLE, IN 47331			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE	
	§491.12, and ESF	RD Facilities at §494.62]:						
	exercises to test to annually. The [fact following:	facility] must conduct he emergency plan ility] must do all of the full-scale exercise that is						
	community-based							
	1	nunity-based exercise is						
	not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual							
		ade emergency that requires						
		mergency plan, the [facility]						
	-	gaging in its next required or individual, facility-based						
	-	e following the onset of the						
	actual event.	e following the offset of the						
		ditional exercise at least						
	' '	posite the year the full-scale						
		cise under paragraph (d)(2)						
		s conducted, that may						
	include, but is not	limited to the following:						
	` '	scale exercise that is						
	-	or individual, facility-based						
	functional exercise	•						
	(B) A mock disast							
	` '	ercise or workshop that is						
	discussion using a	and includes a group						
	_	emergency scenario, and a						
	set of problem sta							
	-	pared questions designed						
	to challenge an er	· · · · · · · · · · · · · · · · · · ·						
		acility's] response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
		rgency plan, as needed.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 2 of 63

PRINTED: 08/10/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED		
		155491	B. W	ING		07/18/2022		
NAME OF	DDOWNED OD CLIDDLIE	D.	•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	K		1029 E	5TH STREET			
MAJEST	TIC CARE OF CONI	NERSVILLE		CONNE	RSVILLE, IN 47331		_	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	*[For Hospices at	` / -						
		ospices that provide care in						
	•	e. The hospice must						
		s to test the emergency						
	1 -	ually. The hospice must do						
	the following:							
		a full-scale exercise that is						
		l every 2 years; or						
		nunity based exercise is not						
		uct an individual facility						
		exercise every 2 years; or						
	1 ' '	experiences a natural or						
	man-made emerg	gency that requires activation						
	of the emergency	plan, the hospital is						
	exempt from enga	aging in its next required full						
	scale community-	based exercise or individual						
	facility-based fund	ctional exercise following the						
	onset of the emer	gency event.						
	(ii) Conduct an a	dditional exercise every 2						
	years, opposite th	ne year the full-scale or						
	functional exercis	e under paragraph (d)(2)(i)						
	of this section is of	conducted, that may						
	include, but is not	t limited to the following:						
	1 ' '	-scale exercise that is						
	community-based	d or a facility based						
	functional exercis	e; or						
	(B) A mock disas	ster drill; or						
	(C) A tabletop ex	ercise or workshop that is						
	led by a facilitator	and includes a group						
	discussion using	a narrated,						
	clinically-relevant	emergency scenario, and a						
	set of problem sta	atements, directed						
	messages, or pre	pared questions designed						
	to challenge an e	mergency plan.						
	(2) Tooting for ba	onione that provide innations						
		spices that provide inpatient e hospice must conduct						
		•						
	L exercises to test t	the emergency plan twice	1				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

per year. The hospice must do the following: (i) Participate in an annual full-scale exercise

E2BG21

Facility ID: 000316

If continuation sheet

Page 3 of 63

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/18/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION		
	accessible, condulation facility-based functions are mergency exempt from engal full-scale communifunctional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, emergency scenal statements, direct questions designed emergency plan. (iii) Analyze the homaintain document exercises, and emergency scenal statements are mergency plan. (iii) Analyze the homaintain document exercises, and emergency scenal for the hospice's emergency plan. (iii) Analyze the hospice's emergency plan	cunity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required atty based or facility-based or facility based or facility or facility or facility or facility based or fa					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155491	B. W	. WING			07/18/2022	
Manage of the	DROLUDER OR CURRY	n.		STREET A	ADDRESS, CITY, STATE, ZIP COD	1		
NAME OF F	PROVIDER OR SUPPLIE	К		1029 E	5TH STREET			
MAJEST	IC CARE OF CON	NERSVILLE		CONNE	ERSVILLE, IN 47331			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, The state of the	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		uct an annual individual,						
	1	ctional exercise; or						
	,	Hospital, CAH] experiences						
		or man-made emergency						
		vation of the emergency						
		is exempt from engaging in full-scale community based						
	I	lity-based functional exercise						
		et of the emergency event.						
		an [additional] annual						
	1 ' '	nat may include, but is not						
	limited to the follo	-						
		-scale exercise that is						
	community-based							
	1	ctional exercise; or						
	1	ock disaster drill; or						
	` ′	p exercise or workshop that						
		tor and includes a group						
	discussion, using	— ·						
	_	emergency scenario, and a						
	set of problem sta	atements, directed						
	messages, or pre	pared questions designed						
	to challenge an e	mergency plan.						
	·	the [facility's] response to					1	
		umentation of all drills,					1	
	1	s, and emergency events						
	·	cility's] emergency plan, as						
	needed.							
	*[For PACE at §4	·60.84(d):]						
	-	PACE organization must					1	
	conduct exercises	s to test the emergency						
	plan at least annu	ually. The PACE						
	organization mus	t do the following:						
		an annual full-scale exercise						
	that is community	/-based; or						
	, ,	nunity-based exercise is not						
		uct an annual individual,						
	1	ctional exercise; or						
	(B) If the PACE e	experiences an actual natural						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIE		1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	activation of the exempt from enfull-scale community-based functional exercises of this section is of this section in this section in this section is of this section in this section in this section is of this section in this section in this section is of this section in this section in this section is of this section in this section in this section is of this section in this section in this section is of this section in this section in this section is section.	an additional exercise every the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop nergency events and revise gency plan, as needed. Estat §483.73(d):] Estat §483.73(d):]			

FORM CMS-2567(02-99) Previous Versions Obsolete

actual natural or man-made emergency that

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 6 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155491	B. W.	ING		07/18/2022		
NAME OF S	DD OTABLE OF START			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	ζ.		1029 E	5TH STREET			
MAJEST	TIC CARE OF CON	NERSVILLE		CONNE	ERSVILLE, IN 47331			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DETICIENC!)		DATE	
	1	n of the emergency plan, the mpt from engaging its next						
		alle community-based or						
		based functional exercise						
		et of the emergency event.						
	_	dditional annual exercise						
	1 ' '	but is not limited to the						
	following:							
	_	-scale exercise that is						
	community-based	l or an individual, facility						
	based functional	exercise; or						
	(B) A mock disas	ter drill; or						
	(C) A tabletop exercise or workshop that is							
	led by a facilitator	- ·						
	discussion, using							
	1	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er							
		LTC facility] facility's						
		maintain documentation of						
		exercises, and emergency						
	· ·	e the [LTC facility] facility's						
	emergency plan,	as needed.						
	*[For ICF/IIDs at §	· /-						
		CF/IID must conduct						
		he emergency plan at least						
	1	ne ICF/IID must do the						
	following:							
		n annual full-scale exercise						
	that is community							
		nunity-based exercise is not						
	· ·	ıct an annual individual,						
		ctional exercise; or.						
		experiences an actual						
		ade emergency that requires						
		mergency plan, the ICF/IID						
		ngaging in its next required						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 7 of 63

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	COMPLETED
		155491	B. WING		07/18/2022
		1			
NAME OF I	PROVIDER OR SUPPLIEF	3		REET ADDRESS, CITY, STATE, ZII	P COD
		-		29 E 5TH STREET	
MAJEST	IC CARE OF CON	NERSVILLE	CC	ONNERSVILLE, IN 47331	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX			PREF	PROVIDER'S PLAN OF C	ORRECTION
	``	ICY MUST BE PRECEDED BY FULL	1	CROSS-REFERENCED TO TH	HE APPROPRIATE
TAG		R LSC IDENTIFYING INFORMATION	TA	G BELIEFER.	DATE
	1	ctional exercise following the			
	onset of the emer				
	1 ' '	Iditional annual exercise			
		but is not limited to the			
	following:				
		scale exercise that is			
	community-based				
	,	ctional exercise; or			
	(B) A mock disast	•			
	1 ' '	ercise or workshop that is			
		and includes a group			
	discussion, using				
	clinically-relevant emergency scenario, and a				
	set of problem statements, directed				
	messages, or pre	pared questions designed			
	to challenge an er	mergency plan.			
	(iii) Analyze the IC	CF/IID's response to and			
	maintain documer	ntation of all drills, tabletop			
	exercises, and en	nergency events, and revise			
		rgency plan, as needed.			
	*[For HHAs at §48	34.1021			
		e HHA must conduct			
		he emergency plan at			
		e HHA must do the			
	following:				
		full-scale exercise that is			
	community-based				
	1	community-based exercise			
	` '	conduct an annual			
		based functional exercise			
	every 2 years; or.				
		A experiences an actual			
		ade emergency that requires			
		mergency plan, the HHA is			
		aging in its next required			
		nity-based or individual,			
	1	ctional exercise following the			
	onset of the emer				
	(ii) Conduct an ad	lditional exercise every 2			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 8 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTI A. BUILD B. WING			(X3) DATE COMPL 07/18/	ETED
	OF PROVIDER OR SUPPLIED		10	029 E 5	DDRESS, CITY, STATE, ZIP COD 5TH STREET RSVILLE, IN 47331	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	years, opposite the functional exercises of this section is community-based facility-based functional functiona	re year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or pexercise or workshop that tor and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop intergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lift the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 9 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETE				
		155491	B. WI	NG		07/18/	2022
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the [RNHCI's and needed.	OPO's] emergency plan, as					
	exercises to test to RNHCI must do the RNHCI must do the conduct a paper at least annually, group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain document exercises, and enthe RNHCI's eme Based on record restailed to conduct explan at least twice punannounced staff procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a communaccessible, conduct facility-based funct b. If the LTC facility or man-made emergof the emergency perform engaging its in community-based of the conset of the activation of the conset of the conset of the conset of the activation of the conset	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. riew and interview, the facility tercises to test the emergency per year, including drills using the emergency re facility must do the annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. The exercise an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a for individual, facility-based I exercise for 1 year following titional exercise that may timited to the following:	E 00)39	1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practi 1. All residents have the potential to be affected. The facility conducted a full scale exercise and exercise of choic Both were completed no later 8-10-2022. 2. How other residents has the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected by the alleged deficient practice. The facility conducted a full scale exercise and exercise of choices.	ice. ce. than aving the	08/10/2022

08/10/2022 PRINTED:

	TOF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331			
(X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or preparthallenge an emerginal (iii) Analyze the LT maintain documentate exercises, and emer LTC facility's emergacordance with 42 deficient practice of Findings include: Based on record revolution of precedure and 2:15 p.m., documentation of an (1) full-scale exercice during the pattern of the time of record commented that the drills." The finding was revoluted by the pattern of the time of record commented that the drills."	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, in statements, directed ed questions designed to ency plan. C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This ould affect all occupants. riew of the Emergency d interview with the atining, Executive Director and or on 07/18/22 between 11:00		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY) Both were completed no later 8-5-2022. On 7-19-2022 the facility Administrator educated Maintenance Director regarding the regulation of having a full exercise and exercise of choic completed every 12 months. 3. What measures will be into place and what systemic changes will be made to ensure the deficient practice does recur. 1. The facility Maintenance Director/designee will conduct both a full scale exercise and exercise of choice yearly. A calendar will be kept by the Maintenance Director as to whoth exercises will be comple by. 4. How the corrective action(s) will be monitored to ensure the deficient practice whot recur, i.e., what quality assurance program will be purplace. 1. For quality assurance, Maintenance Director/designed will review any findings yearly subsequent corrective action education for identified staff.	than d the ng scale ce e put ure s not the will t into the ee y, with	(X5) COMPLETION DATE	

E2BG21

determined.

2. Findings will be reported at the QA meeting monthly or until substantial compliance has been

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/18/2022
	PROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP COD ESTH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) LD BE COMPLETION OPRIATE DATE
				5. Date of Complianc 8-10-2022	e:
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/18 Facility Number: 0 Provider Number: 100 At this Life Safety of Connersville was for Requirements for Pomedicare/Medicaid Life Safety from Fire National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) The facility consiste the East Building (2) which were determine construction and full has a fire alarm systific corridors and sp	200316 155491 286370 Code survey, Majestic Care of bund not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies, and 410 IAC 16.2. Ed of two, one story buildings, 2) and the West Building (1), and to be of Type V (111) ally sprinkled. Each building term with smoke detection in acces open to the corridor.	K 0000	The creation and submis this Plan of Correction d constitute an admission provider of any conclusi forth in the statement of deficiencies, or any viola regulation. /b>	loes not by this on set

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 12 of 63

PRINTED: 08/10/2022

DEPARTMENT SENTERS FOR	FORM APPROVED OMB NO. 0938-039				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE			1029 E	ADDRESS, CITY, STATE, ZIP COD E 5TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
V 0044	were sprinkled and services were sprin Quality Review con	idents have customary access all areas providing facility klered. mpleted on 07/28/22			
K 0211 SS=E Bldg. 01	discharges, exit le in accordance wit of egress is continual obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7. Based on observating failed to ensure 1 of were continuously obstructions. This residents. Findings include: Based on observating of the facility with Executive Director 07/18/22 between 2 exit corridor near residents bed protruding into Based on an intervitient Maintenance Described the corridor obstructions.	- General ays, corridors, exit ocations, and accesses are h Chapter 7, and the means nuously maintained free of full use in case of as modified by 18/19.2.2 1. 1.10.1 on and interview, the facility f 8 corridor means of egresses	K 0211	1. What corrective action will be accomplished for thos residents found to have beer affected by the deficient practice. 1. Residents on the 700 have the potential to be affected by the deficient practice. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by the alleged deficient practice. 2. A campus wide review.	ese n ctice. Unit cted. naving y the ne e

FORM CMS-2567(02-99) Previous Versions Obsolete

Director at the time of discovery and again at the

exit conference with the Executive Director,

Administrator in Training and Maintenance

Event ID:

E2BG21

Facility ID: 000316

completed to ensure no other

beds or obstructions were present

in any hall or unit in both the East

If continuation sheet

Page 13 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/18/2022
ROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	
C CARE OF CONN SUMMARY S (EACH DEFICIEN		1029 E	5TH STREET	ctor on of es put re s not ce te a r 3 f the asure are will t into
			will review any findings daily, subsequent corrective action education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has bedetermined.	with and ed at ntil
			5. Date of Compliance:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 14 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPL 07/18 /	ETED
	PROVIDER OR SUPPLIEF			1029 E	DDRESS, CITY, STATE, ZIP COD 5TH STREET RSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					8-10-2022		
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special loc clinical security nest used, only one loc permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special loc safety needs of the the Clinical or Secare being met. In selectrical locks that release upon loss building is protected automatic sprinkle space is protected detection system at an attended loc space); and both the control of t	king arrangements for the eds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ded by staff at all times; or e means available to the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 15 of 63

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155491	B. WI	NG		07/18/2022	
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			5TH STREET		
MA IEST	IC CARE OF CON	JEDSVII I E			ERSVILLE, IN 47331		
IVIAJEST	IC CARE OF CON	NEKSVILLE		COMME	ENSVILLE, IN 47551		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
	Approved, listed of	delayed-egress locking					
	systems installed	in accordance with					
	7.2.1.6.1 shall be	permitted on door					
	assemblies servin	ng low and ordinary hazard					
	contents in buildir	ngs protected throughout by					
	an approved, sup	ervised automatic fire					
	detection system	or an approved, supervised					
	automatic sprinkle	er system.					
	18.2.2.2.4, 19.2.2	.2.4					
	ACCESS-CONTR	ROLLED EGRESS					
	LOCKING ARRAI	NGEMENTS					
	Access-Controlled	d Egress Door assemblies					
	installed in accord	dance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					
	ELEVATOR LOBI	BY EXIT ACCESS					
	LOCKING ARRAI	NGEMENTS					
	Elevator lobby exi	it access door locking in					
	accordance with 7	7.2.1.6.3 shall be permitted					
	on door assemblie	es in buildings protected					
	throughout by an	approved, supervised					
	automatic fire det	ection system and an					
	approved, superv	ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2	.2.4					
	Based on observation	on and interview, the facility	K 02	222	 What corrective action(s 	s)	08/10/2022
		f over 10 means of egress were			will be accomplished for those		
	readily accessible f	or residents without a clinical			residents found to have been		
		specialized security measures.			affected by the deficient practi	ce.	
	_	aired means of egress shall not			 All residents and visitors 		
		latch or lock that requires the			have the potential to be affect	ed.	
		from the egress side unless			All common exit doors were		
	_	d by LSC 19.2.2.2.4.			equipped with a labeled instru	ction	
		gements shall be permitted in			of how to enter a numbered co	ode	
	accordance with 19	.2.2.2.5.2. This deficient			to exit the facility. Door codes	to	
	practice could affect	et over 15, staff and visitors if			be placed at each common ex	it	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 16 of 63

08/10/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/18/2022 155491 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE needing to exit the facility. door by 8-10-2022. Findings include: Based on observation and interview during a tour How other residents having of the facility with the Administrator in Training, the potential to be affected by the Executive Director and Maintenance Director on same deficient practice will be 07/18/22 between 2:15 p.m. and 6:00 p.m., the identified and what corrective following exit doors, marked as a facility exit, were action(s) will be taken. magnetically locked and could be opened by entering a four-digit code but the code was not All Residents have the posted at the exits or an inaccurate code was potential to be affected by this posted. practice. A) The front door main entrance/exit (West Building) (inaccurate code). A campus wide review was B) Facility Exit door near the Activities Director completed to ensure all common office (not posted). exit doors had a label with instructions on how to exit the C) Facility Exit doors from the Therapy Area (code not posted and believed code not working. facility. The Administrator in Training commented "none of the known codes are working." Maintenance Director was D) 900 Hall corridor exit door (code not posted). educated on the regulation of E) Main Entrance (East Building) (code not ensuring labels are posted at all posted). common exit doors for exiting the F) Exit between the 200 and 300 hall in East facility. building (not posted). G) 200 Hall exit door (not posted). What measures will be put H) The Gate outside the 200 Hall Exit (code not into place and what systemic posted). changes will be made to ensure that the deficient practice does not recur. The finding was reviewed with the Executive Director at the time of discovery and again at the The facility Maintenance exit conference with the Executive Director, Director/designee will complete a

FORM CMS-2567(02-99) Previous Versions Obsolete

3.1-19(b)

Director present.

Administrator in Training and Maintenance

Event ID:

E2BG21

Facility ID: 000316

the facility.

If continuation sheet

100% audit 5 times a week for 3

months during his rounding of the East and West buildings to ensure

common exit doors have a label with instructions on how to exit

Page 17 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022
	PROVIDER OR SUPPLIE		1029 E	ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				 How the corrective action(s) will be monitored to ensure the deficient practice wonot recur, i.e., what quality assurance program will be put place. For quality assurance, Maintenance Director/designe will review any findings daily, would subsequent corrective action a education for identified staff. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined. Date of Compliance: 8-10-2022 	t into the ee with and ed at
K 0281 SS=E Bldg. 01	discharge, is arra and shall be eithe or capable of automanual interventi 18.2.8, 19.2.8 Based on observati failed to provide li along the paths of	eans of Egress eans of egress, including exit inged in accordance with 7.8 er continuously in operation comatic operation without	K 0281	What corrective action(s will be accomplished for those residents found to have been	•

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

19.2.8 and 7.8. This deficient practice could affect

E2BG21

Facility ID: 000316

If continuation sheet

residents found to have been

affected by the deficient practice.

Page 18 of 63

, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
		155491	B. WING	j		07/18/	2022
			5	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.			5TH STREET		
MAJEST	IC CARE OF CONN	IERSVILLE			ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
		ding at the facility at the time					
	-	ell as an indeterminable number			 Residents and visitors 		
	of staff and visitors				exiting the Southwest exit fron		
					the West building on the 900 h		
	Findings include:				have the potential to be affected		
					The facility Maintenance Direct	tor	
		on and interview during a tour			installed lighting at that exit to		
		the Administrator in Training,			light the sidewalk for easy exit		
		and Maintenance Director on			from the facility.		
		:15 p.m. and 6:00 p.m., the exit s from the Southwest exit from			O Hawadhaa		
	_				2. How other residents ha	•	
		lid not have egress lighting for walks from the exit to the			the potential to be affected by		
	*	on interview at the time of			same deficient practice will be identified and what corrective		
		dministrator in Training and					
		confirmed there were no other			action(s) will be taken.		
		minating the sidewalks, and			All Residents have the		
	stated it was undete	_			potential to be affected by this		
		t paths were provided with any			practice.		
	other egress lighting	-			practice.		
		-			2. A campus wide review	was	
	The finding was rev	viewed with the Executive			completed to ensure appropria		
	Director at the time	of discovery and again at the			lighting of all egress areas of t		
	exit conference with	n the Executive Director,			facility.		
	Administrator in Tr	aining and Maintenance					
	Director present.				Maintenance Director w	/as	
					educated on the regulation of		
	3.1-19(b)				ensuring all egress areas of th	e	
					facility are properly illuminated	l.	
					0 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	4	
					3. What measures will be	put	
					into place and what systemic		
					changes will be made to ensur		
					that the deficient practice does	S IIUl	
					recur.		
					1. The Maintenance		
					Director/designee will complet	e a	
					100% audit 5 times a week for		
					months during his rounding of	the	

PRINTED: 08/10/2022

	F OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155491	B. W	ING		07/18	/2022
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF CONN	IERSVILLE			5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0291 SS=F	NFPA 101 Emergency Lightii	ng			East and West buildings to enall egress areas are properly illuminated. 4. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be puplace. 1. For quality assurance, Maintenance Director/design will review any findings daily, subsequent corrective action education for identified staff. 2. Findings will be report the QA meeting monthly or unsubstantial compliance has be determined. 5. Date of Compliance: 8-10-2022	will the ee with and ed at ntil	
Bldg. 01	Emergency Lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour ed automatically in	K 0	291	What corrective action	(s)	08/10/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

failed to ensure 1 of 5 battery powered emergency

lights were maintained in accordance with LSC 7.9.

lights shall use only reliable types of rechargeable

LSC 7.9.2.6 states battery operated emergency

batteries provided with suitable facilities for

Event ID:

E2BG21

Facility ID: 000316

will be accomplished for those

residents found to have been

affected by the deficient practice.

exiting the Southwest exit from

Residents and visitors

Page 20 of 63 If continuation sheet

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155491	B. W	ING		07/18/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			5TH STREET		
MAJEST	IC CARE OF CON	NEDSVILLE			ERSVILLE, IN 47331		
IVIAJEOT	TO CAIL OF CON	NEI (SVIELE		CONNE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	n properly charged condition.			the West building on the 900 I		
		ich lights or units shall be			have the potential to be affect		
		ntended use and shall comply			The facility Maintenance Direct		
		ional Electric Code. LSC 7.9.2.7			installed lighting at that exit to		
	_	by lighting system shall be			light the sidewalk for easy exi	t	
		sly in operation or shall be			from the facility.		
		automatic operation without					
		n. This deficient practice could			2. EXIT lights and emerge	· ·	
	affect all residents,	staff and visitors in the facility.			lighting were fixed to properly		
	F' 1' ' 1 1				illuminate the areas of concer	n.	
	Findings include:				0		
	D				2. How other residents ha	-	
		on and interview during a tour			the potential to be affected by		
	-	the Administrator in Training, and Maintenance Director on			same deficient practice will be	;	
		2:15 p.m. and 6:00 p.m., the			identified and what corrective		
		or battery-operated emergency			action(s) will be taken.		
		ion when its respective test			1 All Decidents have the		
	_	five times. Based on interview			All Residents have the stantial to be affected by this		
	_	bservations, the Maintenance			potential to be affected by this	,	
		dged the aforementioned			practice.		
		nergency light failed to			2. A campus wide review	was	
		espective test button was			completed to ensure egresses		
		re, the EXIT signs located in			were properly illuminated and		
	_	attached to the aforementioned			facility EXIT signs and emerge		
	light did not appear				lighting work properly.	Siloy	
					I agriang were properly.		
	The finding was re	viewed with the Executive			3. Maintenance Director v	was	
		of discovery and again at the			educated on the regulation of		
		h the Executive Director,			ensuring all egress areas of the		
		raining and Maintenance			facility are properly illuminated		
	Director present.				all facility EXIT signs and		
					emergency lighting work prop	erly.	
	3.1-19(b)					-	
					3. What measures will be	put	
	2) Based on observ	ation and interview the facility			into place and what systemic		
	failed to provide en	nergency lighting along the			changes will be made to ensu	re	
	paths of egress in a	ccordance with the			that the deficient practice doe		
	requirements of NF	FPA 101 - 2012 edition, sections			recur.		
	19.2.8 and 7.8. Thi	s deficient practice could affect					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPL	
		155491	B. W	ING		07/18/	/2022
	PROVIDER OR SUPPLIEF			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF all 10 residents resi of the survey, as we of staff and visitors Findings include: Based on observation of the facility with the Executive Director 07/18/22 between 2 discharge sidewalks the West Building of lighting for portions to the public way, of observations, the Executive Director lighting devices illustated it was undete exit paths were pro-	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ding at the facility at the time ell as an indeterminable number		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) 1. The Maintenance Director/designee will completed 100% audit 5 times a week for months during his rounding of East and West buildings to enable all egress areas are properly illuminated and all EXIT signst emergency lighting work property illuminated and all EXIT signst emergency lighting work property in the deficient practice action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be puplace. 1. For quality assurance, Maintenance Director/design will review any findings daily, subsequent corrective action education for identified staff. 2. Findings will be report the QA meeting monthly or u substantial compliance has be determined.	ete a or 3 of the ensure s and perly. will the ee with and ed at edition in the ed at	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire exti				5. Date of Compliance: 8-10-2022		

PRINTED: 08/10/2022

						PKIN	IED:	00/10/2022
DEPARTMENT	OF HEALTH AND HUM	MAN SERVICES				FOI	RM APPI	ROVED
CENTERS FOR	R MEDICARE & MEDICA	AID SERVICES				OM	B NO. 09	38-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155491	B. WI	NG		07/18/	2022	
				CED FEE	ADDRESS STATE TIP SOD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
					5TH STREET			
MAJESTI	IC CARE OF CONN	IERSVILLE		CONNE	ERSVILLE, IN 47331			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(.	X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMP	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DA	ATE
	annroved automat	ic fire extinguishing system						

			PROVIDER'S PLAN OF CORRECTION	(A3)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	approved automatic fire extinguishing system			
	option is used, the areas shall be separated			
	from other spaces by smoke resisting			
	partitions and doors in accordance with 8.4.			
	Doors shall be self-closing or			
	automatic-closing and permitted to have			
	nonrated or field-applied protective plates that			
	do not exceed 48 inches from the bottom of			
	the door.			
	Describe the floor and zone locations of			
	hazardous areas that are deficient in			
	REMARKS.			
	19.3.2.1, 19.3.5.9			
	19.5.2.1, 19.5.5.9			
	Area Automatic Sprinkler			
	Separation N/A			
	a. Boiler and Fuel-Fired Heater Rooms			
	b. Laundries (larger than 100 square feet)			
	c. Repair, Maintenance, and Paint Shops			
	d. Soiled Linen Rooms (exceeding 64			
	gallons)			
	e. Trash Collection Rooms			
	(exceeding 64 gallons)			
	f. Combustible Storage Rooms/Spaces			
	(over 50 square feet)			
	g. Laboratories (if classified as Severe			
	Hazard - see K322)			
	Based on observation and interview, the facility	K 0321	What corrective action(s)	08/10/2022
	failed to ensure 1 of over 10 hazardous area doors,	18 0321	will be accomplished for those	00/10/2022
	such as storage rooms, were provided with		residents found to have been	
	properly working self-closing devices. This			
	deficient practice could affect 3 staff and visitors.		affected by the deficient practice. 1. The Activities Director	
	deficient practice could affect 3 staff and visitors.			
	Findings include:		Office and Bio-hazard Room on	
	i mangs include.		the 300 Unit had self-closing devices installed on the doors.	
	Based on observation and interview during a tour		devices installed off the doors.	
	of the facility with the Administrator in Training,		2 How other residents having	
	Executive Director and Maintenance Director on		2. How other residents having	
	07/18/22 between 2:15 p.m. and 6:00 p.m., The (1)		the potential to be affected by the	
			same deficient practice will be	
	Activities Director office, greater than 50 square		identified and what corrective	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 23 of 63

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 07/18/2022			
	PROVIDER OR SUPPLIER		1029 E	STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) EXECUTE: (X5) COMPLETION DATE			
	such as, paper, plas corridor door to this a self-closing device Bio-Hazard room a contained medical waterials and was redevice. The finding was redevice at the time exit conference with	mber of combustible items, tic, and cardboard boxes. The soffice was not provided with the Event From resident room 317 waste and combustible to equipped with a self-closing riewed with the Executive of discovery and again at the in the Executive Director, aining and Maintenance		action(s) will be taken. 1. All Residents have the potential to be affected by the practice. 2. A campus wide audit completed to ensure all Hazardous areas needing a self-closing device had one installed. 3. Maintenance Directoreducated on the regulation of ensuring all necessary door Hazardous areas had a self-closing device installed working properly. 3. What measures will be into place and what systemic changes will be made to ensure the deficient practice do recur. 1. Maintenance Director/designee will comp 100% audit 5 times a week months during his rounding East and West buildings to all Hazardous areas has wo self-closing devices installed working properly. 4. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be place.	r was of s with and oe put c sure oes not lete a for 3 of the ensure orking d and			

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ODE (X5) COMPLETION DATE		
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment accordance with Noventilation Contro Commercial Cooking appliances such at toasters) are used cooking in accordate 19.3.2.5.2 * cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer proditions under 10 Cooking facilities in NFPA 96 per 9.2.3 enclosed as hazalistics	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. orotected according to 3 are not required to be redous areas, but shall not	TAG	1. For quality assuran Maintenance Director/des will review any findings da subsequent corrective act education for identified states. 2. Findings will be repthe QA meeting monthly of substantial compliance had determined. 5. Date of Compliance 8-10-2022	ice, the ignee hilly, with ion and aff. corted at or until s been		
	be open to the cor						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 25 of 63

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	i '	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/18/2022	
AND FLAN	OF CORRECTION	155491						
MAJEST	PROVIDER OR SUPPLIER	NERSVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
1/10	18.3.2.5.1 through through 19.3.2.5.5.1. Based on observation failed to ensure 1 of extinguishing system working order. NFF 10.1.2 requires cool grease-laden vapors ignition of grease ir device, or duct shall fire-extinguishing ecoking equipment fire-extinguishing sonoperational or in practice was not in 6 kitchen staff.	n 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 ation and interview, the facility of 1 kitchen range hood ms was maintained in proper PA 96, 2011 edition, Section king equipment that produces and that might be a source of in the hood, grease removal	K 0		1. What corrective action(will be accomplished for those residents found to have been affected by the deficient pract 1. All residents have the potential to be affected by the alleged deficient practice. Th facility dietary employees wer re-educated on how to exting Grease Fires in the kitchen. A the Maintenance Director realigned the range hood extinguishing system nozzles the cooking equipment.	e cice. e e e e uish Also,	08/10/2022	
	of the facility with the Executive Director 07/18/22 between 2 kitchen range hood were not properly pequipment under the pointed and oriented over actual appliance confirmed the nozzi positioned over the of this survey. The finding was revenue birector at the time exit conference with	on and interview during a tour the Administrator in Training, and Maintenance Director on :15 p.m. and 6:00 p.m., the extinguishing system nozzles ositioned over the cooking e hood. All nozzles were d in locations which were not less. The Maintenance Director less did not appear to be cooking equipment at the time viewed with the Executive of discovery and again at the h the Executive Director, aining and Maintenance			 How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. All Residents have the potential to be affected by this practice. The facility dietary employees were re-educated how to extinguish Grease Fire the kitchen. Also, the Maintenance Director realigned the range hood extinguishing system nozzles over the cook equipment. Maintenance Director veducated on the regulation of 	or the ee e		

2. Based on observation and interview, the facility failed to ensure staff were instructed in the use of

E2BG21

ensuring dietary staff are educated regarding extinguishing grease

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
		155491	B. W	ING		07/18/	/2022	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE	
		stem in 1 of 1 Kitchen. NFPA			fires and also ensuring that the	е		
	· ·	tructions for manually			range hood extinguishing syst			
		tinguishing system shall be			nozzles are positioned over th	е		
		ly in the kitchen and shall be			cooking equipment.			
	-	loyees by management. This						
	-	ould affect 6 staff in the kitchen			3. What measures will be	put		
	and 25 residents in	the dining room.			into place and what systemic			
					changes will be made to ensu			
	Findings include:				that the deficient practice does	s not		
	Dagad on abassur-4:	on and interview during a tour			recur.			
		on and interview during a tour the Administrator in Training,			1 Maintanana			
		and Maintenance Director on			1. Maintenance Director/designee will complet	· A 3		
		:15 p.m. and 6:00 p.m., the			100% audit 5 times a week for			
		building contained a UL 300			months during his rounding of			
		K-class fire extinguisher with			East and West buildings to en			
	-	Based on interview, the			that the range hood extinguish			
	-	e appliance was asked; what is			system nozzles are over the	g		
	-	e if there was a grease fire			cooking equipment.			
	-	d. The employee replied,						
		ner." When asked, "do you			4. How the corrective			
	know when to use y	our hood suppression pull			action(s) will be monitored to			
	station?" The emplo	oyee replied. "that's for a fire			ensure the deficient practice v	vill		
	anywhere in the kite	chen." The Executive Director			not recur, i.e., what quality			
	acknowledged the r	-		assurance program will be put into				
	additional training v	would be necessary.			place.			
	ent or ti							
	-	viewed with the Executive			1. For quality assurance,			
		of discovery and again at the			Maintenance Director/designe			
		h the Executive Director,			will review any findings daily,			
		aining and Maintenance			subsequent corrective action a	ana		
	Director present.				education for identified staff.			
	3.1-19(b)				2. Findings will be reporte	nd at		
	5.1 17(0)				the QA meeting monthly or un			
					substantial compliance has be			
					determined.			
					5. Date of Compliance:			
					8-10-2022			

PRINTED: 08/10/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155491 B. WING 07/18/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0346 **NFPA 101** SS=F Fire Alarm System - Out of Service Bldg. 01 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. Based on record review and interview, the facility What corrective action(s) 08/10/2022 K 0346 failed to provide a complete 1 of 1 written policy will be accomplished for those for the protection of residents indicating residents found to have been procedures to be followed in the event the fire affected by the deficient practice. alarm system has to be placed out of service for All residents have the four hours or more in a twenty-four-hour period in potential to be affected by the accordance with LSC, Section 9.6.1.6. This alleged deficient practice. The deficient practice affects all occupants. Administrator amended the Fire Watch Plan to include contacting Findings include: ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the Based on record review and interview with the primary method or by the Administrator in Training, Executive Director and secondary method if ISDH Maintenance Director on 07/18/22 between 11:00 Gateway is non-operational by a.m. and 2:15 p.m., the fire watch plan failed to completing the Incident Reporting include contacting the Indiana State Department form and emailing it to of Health via the ISDH Gateway link at incidents@isdh.in.gov. https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to How other residents having incidents@isdh.in.gov. Based on interview during the potential to be affected by the

FORM CMS-2567(02-99) Previous Versions Obsolete

the record review, the Executive Director

acknowledged the fire watch documentation

provided stated to contact the Indiana State

Event ID:

E2BG21

Facility ID: 000316

same deficient practice will be

identified and what corrective

action(s) will be taken.

If continuation sheet

Page 28 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/18/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) RIATE COMPLETION DATE		
TAG	Department of Hear via the ISDH Gatev listed above. The finding was rev Director at the time exit conference with	Ith at a phone number, and not vay link or at the e-mail address viewed with the Executive of discovery and again at the in the Executive Director, aining and Maintenance	TAG	1. All Residents have the potential to be affected by the practice. 2. The facility Administreducated the Maintenance Director and Administrator-In-Training on regulation of properly report incidents as follows: contact ISDH via the ISDH Gateway https://gateway.isdh.in.gov aprimary method or by the secondary method if ISDH Gateway is non-operational completing the Incident Repform and emailing it to incidents@isdh.in.gov. 3. What measures will be into place and what systemi changes will be made to ensthat the deficient practice do recur. 1. The Administrator will annually the proper docume of reporting incidents as followed in the incident in the incident Repform and emailing it to incidents@isdh.in.gov.	ator the ing ting / link at as the by porting pe put c sure pes not Il audit entation ows: IH as the by		
				4. How the corrective			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 29 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/18/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112		
				action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be puplace. 1. For quality assurance, Administrator/designee will re	will ut into the		
				any findings yearly, with subsequent corrective action education for identified staff.			
				Findings will be report the QA meeting monthly or u substantial compliance has b determined.	ntil		
				5. Date of Compliance: 8-10-2022			
K 0354 SS=F Bldg. 01	extent and duration been determined, are inspected and recommendations management or durand the fire depart having jurisdiction the sprinkler systems 10 hours in a building or portion evacuated or an aprovided until the returned to service.	or Out of Service er system is impaired, the en of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, ement and other authorities have been notified. Where m is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 30 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/18/2022		
	PROVIDER OR SUPPLIES			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET		
MAJEST	IC CARE OF CONN	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		view and interview, the facility	K 0	354	What corrective action(s	s)	08/10/2022
	•	of 1 correct written policy in the			will be accomplished for those	;	
		sprinkler system has to be			residents found to have been		
	_	ce for 10 hours or more in a			affected by the deficient practi		
	-	ccordance with LSC, Section			residents have the pote	ntial	
		quires sprinkler impairment			to be affected by the alleged		
		with NFPA 25, 2011 Edition,			deficient practice. The		
		Inspection, Testing and			Administrator amended the Fi		
		ater-Based Fire Protection			Watch Plan to include contact	-	
		5, 15.5.2 requires nine			ISDH via the ISDH Gateway li		
	procedures that the impairment coordinator shall				https://gateway.isdh.in.gov as	the	
	follow. A.15.5.2 (4) (b) states a fire watch should				primary method or by the		
	consist of trained personnel who continuously patrol the affected area. Ready access to fire				secondary method if ISDH		
	-	-			Gateway is non-operational by		
		he ability to promptly notify			completing the Incident Repor	ting	
	_	are important items to			form and emailing it to		
		e patrol of the area, the person			incidents@isdh.in.gov		
		looking for fire, but making ire protection features of the			2. How other residents ha	v de a	
		ress routes and alarm systems			2. How other residents hat the potential to be affected by	-	
		nctioning properly. This			same deficient practice will be		
		ould affect all occupants in the			identified and what corrective		
	facility.	outd affect an occupants in the			action(s) will be taken.		
	idenity.				action(3) will be taken.		
	Findings include:				All Residents have the		
	8				potential to be affected by this		
	Based on record rev	view and interview with the			practice.		
	Administrator in Ti	raining, Executive Director and			'		
	Maintenance Direct	tor on 07/18/22 between 11:00			2. The facility Administrate	or	
	a.m. and 2:15 p.m.,	the fire watch plan failed to			educated the Maintenance		
	include contacting	the Indiana State Department			Director and		
	of Health via the IS	DH Gateway link at			Administrator-In-Training on the	ne	
	https://gateway.isdl	h.in.gov as the primary method			regulation of properly reporting	g	
		method when the ISDH			incidents as follows: contactin	g	
		rational by completing the			ISDH via the ISDH Gateway li	nk at	
		form and e-mailing it to			https://gateway.isdh.in.gov as	the	
	,	gov. Based on interview during			primary method or by the		
		the Executive Director			secondary method if ISDH		
	_	fire watch documentation			Gateway is non-operational by	/	
	provided stated to o	contact the Indiana State			completing the Incident Repor	ting	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 31 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BU	A. BUILDING <u>01</u> COMPI		(X3) DATE : COMPL 07/18/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 5TH STREET	_	
MAJESTI	IC CARE OF CONN	IERSVILLE			ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Department of Heal via the ISDH Gatev listed above. The finding was rev Director at the time exit conference with	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ith at a phone number, and not vay link or at the e-mail address viewed with the Executive of discovery and again at the the Executive Director, aining and Maintenance		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) form and emailing it to incidents@isdh.in.gov. 3. What measures will be into place and what systemic changes will be made to ensut that the deficient practice doe recur. 1. The Administrator will a annually the proper document of reporting incidents as follow contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Report form and emailing it to incidents@isdh.in.gov. 4. How the corrective action(s) will be monitored to ensure the deficient practice who to recur, i.e., what quality assurance program will be purplace. 1. For quality assurance, Administrator/designee will reany findings yearly, with subsequent corrective action education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has been accompliance and the property of the propert	put re s not audit tation to the view and ted at at attil	(X5) COMPLETION DATE
					determined.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 32 of 63

PARTMENT OF HEALTH AND HUMAN SERVICES								
ENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) D.					
AND DE ANY OF CORRESPONDE	TREE MATERIAL MATERIAL PROPERTY.	A DUM DDIG 04						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	(3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) 5. Date of Compliance: 8-10-2022	Έ	(X5) COMPLETION DATE
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to inspect all the facility each mo Portable Fire Exting fire extinguishers show an an animum of the extinguishers show an animum of the extinguishers are check of at least the extinguishers of the extinguishers of the extinguisher of the extinguishers inspections shall ke extinguishers inspective and the extinguishers in the extinguisher and the extinguishers in the extinguisher and th	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility portable fire extinguishers in onth. NFPA 10, Standard for guishers, Section 7.2.1.2 states nall be inspected either ons of an electronic device / on of 30-day intervals. Section or inspection or electronic extinguishers shall include a following items: gnated place on access or visibility reading or indicator in the osition ined by weighing or hefting for extinguishers, extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers nrechargeable extinguishers	K 0	355	1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. All facility fire extinguishers are update with monthly inspections. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure that all facility fire extinguishers are update with monthly inspections. 3. The Maintenance Direct was educated on the regulation.	o to ving the	08/10/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 33 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/18/2022			
MAJEST	ROVIDER OR SUPPLIER C CARE OF CONN SUMMARY	IERSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
	SUMMARY S (EACH DEFICIEN REGULATORY OR performed and the ir performing the insp Section 7.2.4.4 requ are conducted, record shall be kept on a tal extinguisher, on an maintained on file, of Section 7.2.4.5 requ demonstrate that at inspections have been practice could affect Findings include: Based on observation of the facility with the Executive Director at the time extinguisher located documentation of resince 4/22. The finding was rev Director at the time exit conference with	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Initials of the person ection shall be recorded. ires where manual inspections rds for manual inspections g or label attached to the fire inspection checklist or by an electronic method. ires records shall be kept to least the last 12 monthly en performed. This deficient t 6 staff in the lounge. on and interview during a tour he Administrator in Training, and Maintenance Director on 15 p.m. and 6:00 p.m., the tag on the ABC fire I in the Staff Lounge lacked ecent monthly inspections riewed with the Executive of discovery and again at the in the Executive Director,	1029 E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADES) ensuring all fire extinguishers inspected monthly. 3. What measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur. 1. The Maintenance Director/designee will completed 100% audit monthly for 3 monduring his rounding of the East and West buildings to ensure all fire extinguishers are inspermonthly. 4. How the corrective action(s) will be monitored to ensure the deficient practice wont recur, i.e., what quality assurance program will be put place. 1. For quality assurance, Maintenance Director/designee.	put re s not de a daths de te a daths de te de		
	Administrator in Tra Director present. 3.1-19(b)	aining and Maintenance		will review any findings daily, subsequent corrective action a education for identified staff. 2. Findings will be reported the QA meeting monthly or understantial compliance has been determined. 5. Date of Compliance: 8-10-2022	and ed at til		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 34 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET			ETED	
		155491	B. W	ING		07/18/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				5TH STREET		
ΜΔ ΙΕςΤΙ	C CARE OF CONN	IERSVII I E			ERSVILLE, IN 47331		
WAJESTI	C CARL OF CONIN	ILIOVILLE		CONNE	INGVILLE, IN 47551		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting of	corridor openings in other					
	than required encl	osures of vertical openings,					
		s areas resist the passage					
	of smoke and are	made of 1 3/4 inch					
		wood or other material					
	•	g fire for at least 20					
	minutes. Doors in	fully sprinklered smoke					
	compartments are	only required to resist the					
		e. Corridor doors and doors					
	to rooms containing flammable or						
		rials have positive latching					
		atches are prohibited by					
	_	hese requirements do not					
		spaces that do not contain					
	flammable or com						
		n bottom of door and floor					
	-	ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
	-	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	-	rs. Hold open devices that					
		door is pushed or pulled are					
	•	ed protective plates of					
	-	re permitted. Dutch doors					
	-	are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke						
	-	fire window assemblies are					
	•	sprinklered compartments					
		ctions in area or fire					
	-	s or frames in window					
	assemblies.						
	40.000.40.055	D 400 440 400 400					
		Parts 403, 418, 460, 482,					
	483, and 485						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 35 of 63

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
		155491	B. WING			07/18/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF PROVIDER OR SUPPLIER					5TH STREET		
MAJESTIC CARE OF CONNERSVILLE			•	CONNERSVILLE, IN 47331			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG			DATE
	Show in REMARKS details of doors such as fire protection ratings, automatics closing						
	devices, etc.		K 0363				
	Based on observation and interview, the facility				1. What corrective action(What corrective action(s)	
	failed to ensure all corridor doors had no			303	will be accomplished for those	ccomplished for those	
	impediment to closing and latching into the door				residents found to have been		
	frame and would resist the passage of smoke.				affected by the deficient practice.		
	This deficient practice could affect 15 staff and 30				The doors of concern during		
	residents.				the survey have been readjusted		
					and latch positively into their		
	Findings include:				respective door frames.		
	Based on observation and interview during a tour				2. How other residents ha	aving	
	of the facility with the Administrator in Training,				the potential to be affected by	fected by the	
	Executive Director and Maintenance Director on				same deficient practice will be	e	
	07/18/22 between 2:15 p.m. and 6:00 p.m., the				identified and what corrective		
	following corridor doors failed to latch positively				action(s) will be taken.		
	into their respective door frames:						
	a) The double door set into the dining room in				All Residents have the		
	the West building.				potential to be affected by the		
	b) The storage room on the 700 hall - equipped with a self closing device.				alleged deficient practice.		
	c) The storage room by dietary - equipped with			2. A campus wide		vas	
	a self closing device.				completed to ensure all facilit	ensure all facility	
	d) The Kitchen door marked Dietary - equipped				doors latch positively into their		
	with a self closing device.				respective door frames.		
	e) The Laundry corridor door - equipped with a						
	self closing device.						
	f) The 600 hall storage closet - equipped with a				_	vas educated on the regulation of	
	self closing device. g) The unmarked resident room nearest the exit				having all facility doors latch		
	L 07				positively into their respective door		
	to the vent unit did not close and latch positively				frames.		
	into its respective door frame.				3. What measures will be	, nut	
						put	
	The finding was reviewed with the Executive				into place and what systemic changes will be made to ensu	- I	
	Director at the time of discovery and again at the				hat the deficient practice does not		
	exit conference with the Executive Director,			recur.			
	Administrator in Training and Maintenance						
	Director present.				1. Maintenance		

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPL 07/19	
		155491	B. W	_		07/18/	2022
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IE	DATE
	3.1-19(b)				Director/designee will complet 100% audit 2 times a week for months during his rounding of East and West buildings to en that all facility doors latch positively into their respective frames. 4. How the corrective action(s) will be monitored to ensure the deficient practice wont recur, i.e., what quality assurance program will be put place. 1. For quality assurance, Maintenance Director/designe will review any findings daily, would be subsequent corrective action and education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has been determined. 5. Date of Compliance: 8-10-2022	the sure door vill tinto the e with and	
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical w complies with NFF	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 37 of 63

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155491	B. W	NG		07/18/	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			5TH STREET		
MAILCE	IC CARE OF CONN	IEDSVII I E					
WAJEST	IC CARE OF CONI	NERSVILLE		COMME	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	18.5.1.1, 19.5.1.1	, 9.1.1, 9.1.2					
	Based on observa	ation, the facility failed to	K 0	511	1. What corrective action(s	s)	08/10/2022
	ensure 1 of 1 electr	ical junction boxes in the Riser			will be accomplished for those	•	
	room were maintain	ned in a safe operating			residents found to have been		
	condition. LSC 19.	5.1.1 requires utilities comply			affected by the deficient practi	ce.	
	with Section 9.1. L	SC 9.1.2 requires electrical			1. All residents have the		
	wiring and equipme	ent to comply with NFPA 70,			potential to be affected by the		
	National Electrical	Code. NFPA 70, 2011 Edition,			alleged deficient practice. The	Э	
	Article 314.28(3) (c	e) states junction boxes shall be			exposed wiring in the electrica	ıl	
	provided with cover	rs compatible with the box and			junction box was fixed; the ice		
	suitable for the con-	ditions of use. Where used,			machine in the West kitchen h	ad	
	metal covers shall o	comply with the grounding			a GFCI installed; and all electi	rical	
	requirements of 250	0.110. This deficient practice			panels have locks on them.		
	could affect 3 staff.						
					How other residents ha	ıving	
	Findings include:				the potential to be affected by	the	
					same deficient practice will be		
	Based on observation	on and interview during a tour			identified and what corrective		
	of the facility with	the Administrator in Training,			action(s) will be taken.		
		and Maintenance Director on					
		:15 p.m. and 6:00 p.m., an			All Residents with a PI	CC	
	_	oox on the ceiling in the storage			line have the potential to be		
		etary office was not provided			affected by this practice.		
		d exposed electrical wiring					
		oox. The Maintenance Director			A campus wide audit w		
		are of what was going on with			completed to ensure no expos		
	the junction box.				wiring was found in any electri	ical	
					junction boxes and all electricate	al	
	_	viewed with the Executive			panels have locks on them.		
		of discovery and again at the					
		h the Executive Director,			3. Maintenance Director v		
		raining and Maintenance			educated on the regulation of		
	Director present.				having exposed wiring in elect	trical	
					junction boxes and having all		
		ation and interview, the facility			electrical panels equipped with		
		f over 10 wet locations were			locks. In addition, education v		
		nd fault circuit interrupter			provided regarding the necess	•	
		against electric shock. LSC			having GFCI receptacles insta	ılled	
	-	ilities comply with Section 9.1.			around water sources.		
	I I SC 9.1.2 requires	electrical wiring and equipment	1		1		I

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		ľ	JILDING	onstruction 01	(X3) DATE COMPL 07/18 /	ETED	
	F PROVIDER OR SUPPLIEI			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
140	to comply with NF. NFPA 70, NEC 20 Circuit-Interrupter states, ground-fault personnel shall be circuit-interrupter personnel shall have circuit-interrupter personnel shall be personnel	PA 70, National Electrical Code. I1 Edition at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault hall be installed in a readily relling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) ave ground-fault protection for personnel. (3) and (4): Receptacles that are allel and are supplied by a cated to electric snow-melting, and vessel heating equipment to be installed in accordance			3. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur. 1. Maintenance Director/designee will completed 100% audit 2 times a week for months during his rounding of East and West buildings to en no exposed wiring is present, GFCIs are appropriately place and electrical panels are locked. 4. How the corrective action(s) will be monitored to ensure the deficient practice wont recur, i.e., what quality assurance program will be put place. 1. For quality assurance, Maintenance Director/designed will review any findings daily, would be subsequent corrective action and education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined. 5. Date of Compliance: 8-10-2022	put re s not re a 3 the sure re r	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 39 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC LIDENTIFYING INFORMATION TAG Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to the yeground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training,	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
MAJESTIC CARE OF CONNERSVILLE (X4) ID PREFIX TAG Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour			155491	B. WI	NG		07/18/	/2022
MAJESTIC CARE OF CONNERSVILLE (X4) ID PREFIX TAG Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour					STREET A	ADDRESS CITY STATE ZIR COD		
MAJESTIC CARE OF CONNERSVILLE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour	NAME OF I	PROVIDER OR SUPPLIER	₹					
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour	MAJEST	IC CARE OF CONN	JERSVII I E					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour		10 0/11/2 01 00111	VET (O VIEEE		0011112			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour								
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electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour								
ice machine. Findings include: Based on observation and interview during a tour			-					
Findings include: Based on observation and interview during a tour		This deficient pract	ice could affect 5 staff near the					
Based on observation and interview during a tour		ice machine.						
Based on observation and interview during a tour								
		Findings include:						
of the facility with the Administrator in Training,								
		· ·	_					
Executive Director and Maintenance Director on								
07/18/22 between 2:15 p.m. and 6:00 p.m., the ice								
machine in the kitchen was connected to an								
electric receptacle which was being used to power		_						
the freestanding ice machine, with it's own water		1						
supply. The ice machine was located within 3		* * *						
feet of the electric receptacle, and not provided								
with ground fault circuit interruption (GFCI). The								
Maintenance Director at the time of observation								
stated he did not believe the receptacle was on a GFCI circuit.			neve the receptacie was on a					
Of Circuit.		Grei circuit.						
The finding was reviewed with the Executive		The finding was rev	viewed with the Executive					
Director at the time of discovery and again at the								
exit conference with the Executive Director,								
Administrator in Training and Maintenance								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 40 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022			
MAJEST	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SE COMPLETION			
	3. Based on observation failed to ensure all corridors were secupersonnel. NFPA 7 Energized parts of senclosed as specified in 230.620 (A) Enclosed. Energized parts of senclosed as specified in 230.620 (A) Enclosed. Energized the installed or contact or shall be generally be installed or control board and generally and 110.18 and 110.27. guarded as provided means for locking of access to energized deficient practice or residents. Findings include: Based on observation of the facility with the Executive Director 07/18/22 between 2 electrical panels in when tested. Based observation, the Add the electrical panels will need to be relouded. The finding was revisit conference with the conference with	gized parts shall be enclosed to be exposed to accidental guarded as in 230.62(B), gized parts that are not enclosed in a switchboard, panelboard, or unarded in accordance with Where energized parts are and in 110.27(A)(1) and (A)(2), a for sealing doors providing parts shall be provided. This bould affect 10 staff and 26 for and interview during a tour the Administrator in Training, and Maintenance Director on the 300 hall were unlocked on interview at the time of ministrator in Training stated is were unlocked recently and						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 41 of 63

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	CON	MPLETED
		155491	B. W	ING		07/	18/2022
				STREET A	ADDRESS, CITY, STATE, ZIP	COD	
NAME OF P	ROVIDER OR SUPPLIER	8			5TH STREET		
MAJESTI	IC CARE OF CONN	NERSVILLE		CONNERSVILLE, IN 47331			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	PRRECTION	(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE : APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
3		the transmission of a fire					
		simulation of emergency fire					
	_	rills are held at expected					
		mes under varying					
	conditions, at leas	t quarterly on each shift.					
	The staff is familia	ar with procedures and is					
		re part of established					
		rills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	10.7.4.7					
	19.7.1.4 through 1	view and interview, the facility	17.0	710	1 What carrective	a action(a)	00/10/2022
		e drills or documented	K 0	/12	What corrective will be accomplished	• •	08/10/2022
		on each shift for 2 of 4			residents found to have		
		1.6 states drills shall be			affected by the deficie		
	_	on each shift to familiarize			All facility resident	-	
		nurses, interns, maintenance			the potential to be affe		
		inistrative staff) with the			alleged deficient pract	•	
	signals and emerger	ncy action required under			forward from our Plan	•	
	varied conditions.	QSO-20-31 1135 temporary			date the facility will be	conducting	
		ı of a physical fire drill, a			fire drills per shift qua	rterly per	
		tion training program related			regulation.		
		lan, which considers current					
		is acceptable. The training will			How other resi	_	
		including existing, new or			the potential to be affe	-	
		es, on their current duties, life			same deficient practic		
		nd the fire protection devices			identified and what co		
	affects all staff and	ea. This deficient practice			action(s) will be taken	1-	
	arrects arr starr alla	patients.			1. All Residents h	have the	
	Findings include:				potential to be affecte		
	- 1101100				practice.	a 2, 1110	
	Based on record rev	view and interview with the			'		
	Administrator in Tr	raining, Executive Director and			2. Moving forward	d from our	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155491	B. W	'ING		07/18/	2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			5TH STREET		
MAJESTI	IC CARE OF CONN	IERSVILLE			ERSVILLE, IN 47331		
					, 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		for on 07/18/22 between 11:00			Plan of Correction date the fac	•	
	_	the Second shift, second			will be conducting fire drills pe	r	
	-	cumentation was missing and			shift quarterly per regulation.		
	-	of completed orientation			D. T. M		
	training for the abou	ve-mentioned quarter.			3. The Maintenance Direct		
	D1' ('	-44-4:			was educated on the regulation	n ot	
		at the time of record review,			having a fire drill per shift per		
		tor agreed there was one d staff has not been trained in			calendar quarter.		
	_	d starr has not been trained in edures for the second quarter.			3. What measures will be	nut.	
	the fire safety proce	dures for the second quarter.			3. What measures will be into place and what systemic	ραι	
	The finding was rev	viewed with the Executive			changes will be made to ensu	rο	
	-	of discovery and again at the			that the deficient practice does		
		of discovery and again at the the Executive Director,			recur.	5 1101	
		aining and Maintenance			Toodi.		
	Director present.	anning and mannenance			1. The Maintenance		
	Director present.				Director/designee will complet	e an	
	3.1-19(b)				audit quarterly to ensure that t		
	3.1-51(c)				facility has fire drills conducted		
					regulation.	- poi	
					- ogaidaon.		
					4. How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice w	vill	
					not recur, i.e., what quality		
					assurance program will be put	tinto	
					place.		
					1. For quality assurance,	the	
					Maintenance Director/designe		
					will review any findings daily, v	with	
					subsequent corrective action a	and	
					education for identified staff.		
					2. Findings will be reporte	ed at	
					the QA meeting monthly or un	til	
					substantial compliance has be	en	
					determined.		
					5. Date of Compliance:		

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ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155491	A. BU B. WI	ILDING NG	<u>01</u>	COMPL 07/18/		
NAME OF	DD OLUBED OD GUDDU IE			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	K			5TH STREET			
MAJEST	IC CARE OF CON	NERSVILLE		CONNE	ERSVILLE, IN 47331			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY	R LSC IDENTIFYING INFORMATION		TAG	8-10-2022		DATE	
K 0741 SS=F Bldg. 01	shall include not provisions: (1) Smoking shal ward, or compart liquids, combustil used or stored ar location, and suc signs that read N posted with the ir smoking. (2) In health care smoking is prohib prominently place secondary signs smoking shall no (3) Smoking by presponsible shall (4) The requirem apply where the pupervision. (5) Ashtrays of no safe design shall where smoking is (6) Metal contain devices into whice	ons shall be adopted and less than the following I be prohibited in any room, ment where flammable ble gases, or oxygen is and in any other hazardous the area shall be posted with the osmooth of SMOKING or shall be neternational symbol for no a cocupancies where betted and signs are the at all major entrances, with language that prohibits the required. The prohibited is entered to the prohibited is under direct the provided in all areas is permitted. The provided in all areas is permitted in all areas is permitted. The provided in all areas is permitted in all areas where it is all areas where						
	Based on observat	ion and interview; the facility of 2 smoking areas and 1 of 1	K 07	741	What corrective action(will be accomplished for those		08/10/2022	

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Event ID:

non-smoking areas were maintained by disposing

cigarette butts in a metal or noncombustible

E2BG21

Facility ID: 000316

If continuation sheet

residents found to have been

affected by the deficient practice.

Page 44 of 63

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155491	B. W	NG		07/18/	2022
					-		
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		1550) #1 1 5			5TH STREET		
MAJEST	IC CARE OF CONN	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T.C.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	container with self-	closing cover devices. This			All residents have the		
		ould affect all residents.			potential to be affected by the		
	•				alleged deficient practice. All		
	Findings include:				cigarette butts were appropria	telv	
					disposed of in a metal or	,	
	Based on observation	on and interview during a tour			non-combustible container with	h a	
		the Administrator in Training,			self-closing cover device.		
		and Maintenance Director on					
		:15 p.m. and 6:00 p.m., cigarette			2. How other residents ha	vina	
		and prevalent on the ground			the potential to be affected by		
		including but not limited to the			same deficient practice will be		
	following locations				identified and what corrective		
	-	ont entrance, where a no			action(s) will be taken.		
		posted, there were over 10					
		osed on the ground. A			1. All Residents have the		
	-	chair was observed smoking,			potential to be affected by the		
		the front entrance by this			alleged deficient practice. All		
	_	ral. The identity of the resident			cigarette butts were appropria	telv	
		the Executive Director during			disposed of in a metal or	,	
	the facility tour.	Ç			non-combustible container with	h a	
	•	butts outside the Activities			self-closing cover device.		
	Director Exit door.				Ĭ		
	c) More than 75 l	butts outside the Kitchen Exit			2. A campus wide audit of	the	
	door.				facility grounds was completed		
	d) More than 100	butts outside the Memory			eliminate all cigarette butts we		
	Care 300 hall exit in				properly disposed of.		
		S			' ' ' '		
	The finding was rev	viewed with the Executive			3. The Maintenance Direct	tor	
	_	of discovery who stated			was educated on the need to l		
		olem at the facility, and again at			all cigarette butts appropriately	/	
		with the Executive Director,			disposed of in a metal or	'	
		raining and Maintenance			non-combustible container with	h a	
	Director present.	-			self-closing cover device.		
	•						
	3.1-19(b)				3. What measures will be	put	
					into place and what systemic	-	
					changes will be made to ensur	re	
					that the deficient practice does		
					recur.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		ILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022		
	PROVIDER OR SUPPLIE		1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
1.40	REGULATORTO	ESC IDENTIFICATION		1. The Maintenance Director/designee will complete audit 5 times a week for 3 moto ensure all cigarette butts we properly disposed of. 4. How the corrective action(s) will be monitored to ensure the deficient practice work recur, i.e., what quality assurance program will be purplace. 1. For quality assurance, Maintenance Director/designer will review any findings daily, subsequent corrective action education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined. 5. Date of Compliance: 8-10-2022	nths ere vill t into the ee with and ed at util	
K 0914 SS=F Bldg. 01	Testing Electrical System Testing Hospital-grade re locations and who anesthesia is adn initial installation, Additional testing	s - Maintenance and s - Maintenance and ceptacles at patient bed ere deep sedation or general ninistered, are tested after replacement or servicing. is performed at intervals nented performance data.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 46 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01		COMPLETED	
		155491	B. Wl	NG		07/18	/2022	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
MAJEST	IC CARE OF CONN	IERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDEDIG BY AN OF CODD F COMMON		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE	
	these locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visit. LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, reresults. 6.3.4 (NFPA 99) Based on record revinterview; the facility documentation of e testing at all resider review in accordant Health Care Facilitie 6.3.4.1.3 states receives in accordant Health Care Facilitie 6.3.4.1.3 states receives in accordant Health Care Facilities Code, 20 states hospital-grade at pallocations where decanesthesia shall be exceeding 12 month Facilities Code, 20 states hospital-grad performed after initiates after the physical integric confirmed by visual the grounding circuits shall be verified. Concutral connections shall be confirmed;	view, observation and ty failed to ensure lectrical outlet receptacle at rooms was available for the with NFPA 99. NFPA 99, es Code, 2012 Edition, Section	K 0	914	1. What corrective action(swill be accomplished for those residents found to have been affected by the deficient pract 1. All residents have the potential to be affected by the alleged deficient practice. All facility receptacles have teste 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit we completed of all facility receptacles and each receptar was tested.	d. d. aving the	08/10/2022	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIED		1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	than 115 grams (4 of states, at a minimum date, the rooms or a of which items have the performance rearrange of the performance rearrange of the performance rearrange of the performance of the performanc	view and interview with the raining, Executive Director and tor on 07/18/22 between 11:00 an itemized listing of inspection all outlet receptacles within the month period was not v. Furthermore, no ecceptacle testing prior to the onset of the COVID-19 allable for review. Based on the Maintenance Director of facility each resident room in buildings (with the exception the East Building) contained receptacles installed near		3. The Maintenance Direct was educated on the regulation all facility receptacles to be tere and inspected within 12 month the previous inspection/testing. 3. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur. 1. The Maintenance Director/designee will inspect test all facility receptacles with 12 months of the previous inspection/testing. 4. How the corrective action(s) will be monitored to ensure the deficient practice who trecur, i.e., what quality assurance program will be purplace. 1. For quality assurance, Maintenance Director/designed will review any findings yearly subsequent corrective action and education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has been determined. 5. Date of Compliance:	on of sted ins of g. put re s not and in the ee e, with and ed at at at at a stell and a stell a stel
				8-10-2022	

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not used wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 1. Based on observat failed to ensure 1 or in patient care locat rating of 1363A or affects two resident Findings include: Based on observation	ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms b) meet UL 1363. In coms, power strips meet ls. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. d), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 ation and interview, the facility f 1 flexible cords power strips ions met the required UL 60601-1. This deficient practice	K 0920	1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practi 1. The rooms found to be concern during the survey has the power strips removed. Als the multi-plug adapter in the laundry area was removed.	ce. of had		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 49 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY		
			A. BUILDING		COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155491	A. BUILDING B. WING	01	07/18/2022	
		100701			01/10/2022	
NAME OF I	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·		ADDRESS, CITY, STATE, ZIP COD		
NAA IEGE		JEDOVALI E		5TH STREET		
MAJEST	IC CARE OF CONN	NERSVILLE	CONN	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		BATE	
		and Maintenance Director on		2. How other residents ha	_	
		2:15 p.m. and 6:00 p.m., there		the potential to be affected by		
		hat was in use next to the		same deficient practice will be		
		om 702 that did not met 1363A		identified and what corrective		
	or 60601-1.			action(s) will be taken.		
		at the time of observation, the				
		tor agreed a power strip was in		All Residents residing contains and a second contains a secon		
	use next to a resident bed and did not meet 1363A			the memory care unit have the		
	or 60601-1.			potential to be affected by this		
	2 D11	ation and interview, the facility		practice.		
				2 A someonide sudit w		
		f 1 laundry room did not use		2. A campus wide audit w		
	multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and			completed to ensure that only		
	_	in accordance with NFPA 70,		approved power strips are being	-	
		Code. NFPA 70, 2011 Edition,		used and no multi-plug adapte	ers in	
		res that, unless specifically		the laundry areas.		
	_	cords and cables shall not be		3. The Maintenance Direct	tor	
	_	for fixed wiring of a structure.				
	This deficient pract			was educated on the regulatio		
	This deficient pract	ice affects 4 staff.		only approved power strips to	be	
	Findings include:			used in the facility and no multi-plug adapters in the laun	,dn/	
	Findings metade.			areas.	luly	
	Based on observation	on and interview during a tour		aicas.		
		the Administrator in Training,		3. What measures will be	nut	
		and Maintenance Director on		into place and what systemic	Put	
		2:15 p.m. and 6:00 p.m., the		changes will be made to ensur	re.	
		nd the washing machines		that the deficient practice does		
	-	lug adaptor powering		recur.		
		on interview at the time of				
		aintenance Director agreed a		1. The Maintenance		
		r was in use in the laundry area.		Director/designee will audit we	eeklv	
		,		for the use of approved power	-	
	The finding was rev	viewed with the Executive		strips in the facility.		
	_	of discovery and again at the		'		
		h the Executive Director,		4. How the corrective		
		raining and Maintenance		action(s) will be monitored to		
	Director present.			ensure the deficient practice w	/ill	
	F			not recur i.e. what quality		

FORM CMS-2567(02-99) Previous Versions Obsolete

3.1-19(b)

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

assurance program will be put into

Page 50 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BUILDING B. WING	01	COMPLETED 07/18/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0000 Bldg. 03	A Life Safety Code Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	place. 1. For quality assurance, and Maintenance Director/designe will review any findings daily, a subsequent corrective action a education for identified staff. 2. Findings will be reported the QA meeting monthly or undestantial compliance has been determined. 5. Date of Compliance: 8-10-2022 The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or any violation regulation. /b>	the see with and sed at still seen seet		
	At this Life Safety C Connersville was fo Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protec Life Safety Code (L	Code survey, Majestic Care of und not in compliance with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 51 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>03</u> COMPLET			ETED	
		155491	B. WI	NG		07/18/	2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	_	DATE
K 0293 SS=E Bldg. 03	the East Building (2 which were determiconstruction and ful has a fire alarm syst the corridors and sp. The facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of the facility has a cacensus of 99 at the transport of 99 at the trans	dents have customary access all areas providing facility (dered.) Inpleted on 07/28/22 In signs are displayed in 1.0 with continuous erved by the emergency existing less than 30 occupants exit travel is obvious.) In and interview, the facility of 1 emergency Exit and displayed in accordance with entinuous illumination also gency lighting system and	K 0:	293	1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practic 1. EXIT lights and emerger lighting were fixed to properly illuminate the areas of concern 2. How other residents has the potential to be affected by same deficient practice will be identified and what corrective	ce. ncy n.	08/10/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 52 of 63

08/10/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 07/18/2022 155491 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 07/18/22 between 2:15 p.m. and 6:00 p.m., the action(s) will be taken. 600-700 hall corridor battery-operated emergency light failed to function when its respective test All Residents have the button was pushed five times. Based on interview potential to be affected by this at the time of the observations, the Maintenance practice. Director acknowledged the aforementioned battery-operated emergency light failed to A campus wide audit was function when its respective test button was completed to ensure all facility pushed. The EXIT sign located in the vicinity and EXIT signs and emergency lighting attached to the aforementioned light was also not work properly. illuminated. The Maintenance Director stated that the power to the lights might not be turned on at Maintenance Director was the utility breaker box. Because the Maintenance educated on the regulation of Director was new to the facility, he was unsure ensuring all EXIT lights and which breakers controlled the exit and emergency emergency lighting properly lights. illuminate. The finding was reviewed with the Executive What measures will be put Director at the time of discovery and again at the into place and what systemic exit conference with the Executive Director, changes will be made to ensure Administrator in Training and Maintenance that the deficient practice does not Director present. recur. 3.1-19(b)Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure all EXIT signs and emergency lighting work properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. For quality assurance, the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

Maintenance Director/designee

If continuation sheet

Page 53 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BUILDING <u>03</u>			(X3) DATE : COMPL 07/18/	LETED	
	PROVIDER OR SUPPLIE		<u> </u>	1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 0361 SS=E Bldg. 03	Corridors - Areas Spaces (other that treatment rooms waiting areas, nu and cooking facili in accordance with and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observatifailed to ensure 1 of the space of the s	Open to Corridor Open to Corridor an patient sleeping rooms, and hazardous areas), rse's stations, gift shops, ties, open to the corridor are the the criteria under 18.3.6.1 on and interview, the facility of 1 alcoves with a large stible mattresses open to the	K 0	361	will review any findings daily, subsequent corrective action a education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has been determined. 5. Date of Compliance: 8-10-2022	and ed at till een	08/10/2022
	corridor was not us 19.3.6.1(7) states t sleeping rooms, tre areas shall be open in area, provided: (which the space op compartment are p supervised automa accordance with 19 protected by an aut space does not to c	the das hazardous storage. LSC hat spaces other than patient hatment rooms, and hazardous to the corridor and unlimited a) The space and corridors hens onto in the same smoke rotected by an electrically tic smoke detection system in 0.3.4, and (b) Each space is comatic sprinklers, and (c) The abstruct access to required and practice could affect staff and			affected by the deficient practi 1. Residents on the 900 H have the potential to be affect by the alleged deficient practic The wooden pallets and mattresses were removed on 7-19-2022. 2. How other residents ha the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken.	all ed ce. aving the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 54 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIEI		1029 E	ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	of the facility with Executive Director 07/18/22 between 2 Resident Room 90% cardboard boxes an protruding over 4 for obstructing the exit a hazardous area of The finding was reduced by the conference with Executive Director at the time exit conference with the time of the conference with the Executive Director at the time exit conference with the time of the conference with the Executive Director at the time of the conference with the conference	on and interview during a tour the Administrator in Training, and Maintenance Director on 2:15 p.m. and 6:00 p.m., near 7 3 beds and over 50 large d two wooden pallets were eet into the exit corridor from the 900 hall and creating pen to the corridor. viewed with the Executive e of discovery and again at the the the Executive Director, raining and Maintenance		 All Residents with a catheter have the potential to affected by this practice. A campus wide audit we completed to ensure all halls we unobstructed in the East and West Buildings. The Maintenance Direct was educated on the regulation to having obstructed hallway the East and West Buildings. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur. The Maintenance Director/designee will completed 100% audit 5 times a week for months during his rounding of East and West buildings to enthat all hallways are not obstructed. How the corrective action(s) will be monitored to ensure the deficient practice we not recur, i.e., what quality assurance program will be put place. For quality assurance, Maintenance Director/designer will review any findings daily, will review any findings daily. 	ctor on of rs in r put tre s not te a r 3 f the asure will t into

subsequent corrective action and

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 03 COMPLETED B. WING 07/18/2022			
		155491	B. W.	ING		07/18/	/2022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					5TH STREET		
MAJEST	IC CARE OF CON	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					education for identified staff.		
					2. Findings will be reported	ad at	
					the QA meeting monthly or ur		
					substantial compliance has be		
					determined.	,,,,	
					5. Date of Compliance:		
					8-10-2022		
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 03		s - Essential Electric					
	System Maintena						
	1 -	other alternate power					
	_	iated equipment is capable					
	of supplying servi	ce within 10 seconds. If the					
	10-second criterio	on is not met during the					
	monthly test, a pr	ocess shall be provided to					
	I -	this capability for the life					
	1	branches. Maintenance					
	1	generator and transfer					
	•	ormed in accordance with					
	NFPA 110.	en inapported wealthy					
		e inspected weekly, oad 30 minutes 12 times a					
		intervals, and exercised					
	1 -	onths for 4 continuous hours.					1
	1	nder load conditions include					
		ated cold start and					
	I	ual transfer of all EES					
	loads, and are co	nducted by competent					
	personnel. Mainte	enance and testing of stored					
	energy power sou	ırces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and a					
	1 ' -	dically exercising the					
	components is es	tablished according to					1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet

Page 56 of 63

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	of maintenance ar and readily availal and circuits are m and separate from Minimizing the poseus emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on observation failed to ensure 1 of equipped with a protect the event the general Standard for Emerg Systems 2010 Editions that the event the general Standard for Emerg Systems 2010 Editions that the event the general station of a type to punintentional operation of a type to punintentional operation of the prime melsewhere on the prime is located outside the Section 5.6.5.6.1, restation to be labeled. Annex A is not a paincluded for inform A.5.6.5.6 states for manual shutdown significant practical station of the facility with the weatherproof enappropriately idention. This deficient practical swell as staff and Findings include:	(NFPA 99), NFPA 110, 0 (NFPA 70) on and interview, the facility of 1 emergency generators was perly located remote stop in a stor caught fire. NFPA 110, ency and Standby Power on, Section 5.6.5.6, requires all ave a remote manual stop or event inadvertent or the information located outside the room mover, where so installed, or emises where the prime mover are building. Equires the remote manual stop late. In the original purposes only. The systems located outdoors, the mould be located external to inclosure and should be	K 0918	1. What corrective action(will be accomplished for those residents found to have been affected by the deficient pract 1. All residents have the potential to be affected by the alleged deficient practice. The facility installed the generator remote emergency stop on 8-2-2022 for the West facility generator. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. The facility installed the generator remote emergency on 8-2-2022 for the West facility generator. 3. Education was provided the Maintenance Director of the regulation of having an emergency.	ice. e aving the e stop ity d to ne

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BUILDING B. WING	03	COMPLETED 07/18/2022		
	PROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	generator for the W with an emergency located. The Admin Director and Mainte of the location of ar generator. A telepho maintenance profess locating an emerger The finding was rev Director at the time exit conference with	est building was not equipped stop button which could be istrator in Training, Executive enance Director were not sure a emergency stop for the one call to a corporate sional did not assist in		remote stop for emergency generators. 3. What measures will be into place and what systemic changes will be made to ensuthat the deficient practice doe recur. 1. The Maintenance Dire will ensure that the emergency generator has the emergency remote stop. 4. How the corrective action(s) will be monitored to ensure the deficient practice on the recur, i.e., what quality assurance program will be puplace. 1. For quality assurance, Maintenance Director/designed will review any findings daily, subsequent corrective action education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined. 5. Date of Compliance: 8-10-2022	ire is not ctor ctor ctor ctor ctor ctor ctor c	
K 0923 SS=E Bldg, 03	NFPA 101 Gas Equipment - 0	Cylinder and Container				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 58 of 63

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/10/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	03	COMPI	
		155491	B. WI	ING		07/18/2022	
NAME OF	PROVIDER OR SUPPLIE	I.R			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	TIC CARE OF CON	NEDOVII I E	1029 E 5TH STREET CONNERSVILLE, IN 47331				
IVIAJES	TIC CARE OF CON	NERSVILLE		CONNE	NOVILLE, IN 47331		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCIT		DATE
	Storage	Cylinder and Container					
	1	equal to 3,000 cubic feet					
		s are designed, constructed,					
	_	accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000	cubic feet					
		s are outdoors in an					
	enclosure or with	in an enclosed interior					
	space of non- or	limited- combustible					
		n door (or gates outdoors)					
		red. Oxidizing gases are not					
		nables, and are separated					
		es by 20 feet (5 feet if					
		nclosed in a cabinet of					
		construction having a					
		fire protection rating.					
		al to 300 cubic feet					
	_	e compartment, individual					
		le for immediate use in					
		s with an aggregate volume qual to 300 cubic feet are not					
		ored in an enclosure.					
	1 .	e handled with precautions					
	as specified in 11	•					
	1	sign readable from 5 feet is					
		gate of a cylinder storage					
	room, where the	sign includes the wording as					
	a minimum "CAU	ITION: OXIDIZING GAS(ES)					
	STORED WITHI	N NO SMOKING."					
		ed so cylinders are used in					
		ey are received from the					
		cylinders are segregated					
	_	s. When facility employs					
	1 -	egral pressure gauge, a					
		re considered empty is					
	established. Em	pty cylinders are marked to					

FORM CMS-2567(02-99) Previous Versions Obsolete

avoid confusion. Cylinders stored in the open

11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA

are protected from weather.

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

Page 59 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 03 COMPI B. WING 07/18			
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	_
MAJEST	IC CARE OF CONN	NERSVILLE			5TH STREET ERSVILLE, IN 47331	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE
	99)	on and interview, the facility	K 0	022	What corrective action((s) 08/10/2022
		f 2 cylinders of nonflammable	K U	923	will be accomplished for those	• •
		en were properly secured from			residents found to have been	
		Health Care Facilities Code,			affected by the deficient pract	
	_	on 11.3.2 states storage for			1. All residents have the	
	nonflammable gase	s greater than 8.5 cubic meters			potential to be affected by the	e
	,	less than 85 cubic meters			alleged deficient practice. The	ne
		nall comply with 11.3.2.1			facility properly stored "E" typ	e
	1	NFPA 99, Section 11.3.2.6 states			oxygen cylinders either via	
cylinder or container restraints shall comply with					chained or supported in prope	er
11.6.2.3. Section 11.6.2.3(11) states freestanding				cylinder stands or carts.		
	cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient					
					2. How other residents ha	•
	practice could affec	t 4 residents.			the potential to be affected by	
	Findings include:				same deficient practice will be identified and what corrective	
	Tilidings include.				action(s) will be taken.	,
	Based on observation	on and interview during a tour			action(s) will be taken.	
		the Administrator in Training,			All Residents have the	<u>,</u>
		and Maintenance Director on			potential to be affected by this	
		::15 p.m. and 6:00 p.m., one 'E'			practice.	
		er were standing upright on			'	
		t room 90 and not properly			2. The facility properly st	ored
	chained or supporte	ed in a proper cylinder stand or			"E" type oxygen cylinders eith	ner
	cart.				via chained or supported in p	roper
		at the time of observation, the			cylinder stands or carts.	
		tor acknowledged the 'E' type				
		ot properly chained or			3. Education was provide	
	supported in a prop	er cylinder stand or cart.			the Maintenance Director of t	ne
	The finding	riowed with the Evecution			regulation of having "E" type	d in
		viewed with the Executive of discovery and again at the			oxygen cylinders either stored proper cylinder stands/carts of	
		h the Executive Director,			chained to prevent tipping over	
		raining and Maintenance			Tonamed to prevent upping over	GI.
	Director present.	anning and mannonance			3. What measures will be	e nut
	= moster prosent.				into place and what systemic	•
	3.1-19(b)				changes will be made to ensu	
					that the deficient practice doe	
					recur	

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491		JILDING	DNSTRUCTION 03	(X3) DATE COMPL 07/18/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					The Maintenance Director/designee will ensure proper storage of "E" type oxy cylinders 5 times a week for 3 months.		
					4. How the corrective action(s) will be monitored to ensure the deficient practice v not recur, i.e., what quality assurance program will be purplace.		
					For quality assurance, Maintenance Director/designe will review any findings daily, subsequent corrective action a education for identified staff.	e with	
					Findings will be reported the QA meeting monthly or under substantial compliance has been determined.	itil	
					5. Date of Compliance: 8-10-2022		
K 0927 SS=E Bldg. 03	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Higl Oxygen Used for any gas from one prohibited in patie	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21 Facility ID: 000316

If continuation sheet Page 61 of 63

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039											
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	onstruction 03	(X3) DATE SURVEY COMPLETED						
AND I LAN OF CORRECTION		155491	B. WING	<u>00</u>	07/18/2022						
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331								
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)						
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)							
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE						
	under 11.5.2.3.1 (liquid oxygen containers under sconditions under 11.5.2.2 (NFPA 98 Based on observational failed to ensure 1 of provided with proposition. NFPA requires oxygen transmechanically ventilation requires mechanical negative pressure in	11.5.2.3.2 (NFPA 99). 19) 10) 11.5.2.3.2 (NFPA 99). 10) 11.5.2.3.2 (NFPA 99). 12.5.2 oxygen storage rooms was early working mechanical 12.5.2.3.1 (2) 13.5.2.3.1 (2) 14.5.2.3.1 (2) 15.5.3.1 (2) 16.5.2 oxygen storage rooms was early working mechanical 17.5.2.3.1 (2) 18.5.2 oxygen storage rooms was early working mechanical 19.5.2 oxygen storage rooms	K 0927	1. What corrective action(will be accomplished for those residents found to have been affected by the deficient pract 1. All residents have the potential to be affected by the alleged deficient practice. The facility has installed exhaust fin all areas needing them for oxygen storage.	e cice.						
	of the facility with the Executive Director 07/18/22 between 2 oxygen storage room oxygen tanks, the wifunctional mechanical Based on interview Executive Director not appear to be wood The finding was revisible.	on and interview during a tour the Administrator in Training, and Maintenance Director on :15 p.m. and 6:00 p.m., the m contained large liquid ent did not contain a cally ventilated exhaust fan. at the time of observation, the stated the oxygen room fan did rking. Viewed with the Executive of discovery and again at the in the Executive Director, aining and Maintenance		2. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. The facility has installed exhaust fans in all areas need them for oxygen storage. 3. Education was provided the Maintenance Director of the regulation of having exhaust in all areas with oxygen storal and transfilling. 3. What measures will be	or the decided to the fans ge						
				What measures will be into place and what systemic	put						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E2BG21

Facility ID: 000316

If continuation sheet

changes will be made to ensure

Page 62 of 63

PRINTED: 08/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>03</u>		03	COMPLETED		
		155491	B. WING			07/18/2022		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF CONNERSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION CORRECTION CORR		ΛΤΕ	(X5) COMPLETION DATE		
					that the deficient practice does recur.	eficient practice does not		
					 The Maintenance Director/designee will ensure proper exhaust fans are in all areas of oxygen storage and transfilling 5 times a week for months. How the corrective action(s) will be monitored to ensure the deficient practice w not recur, i.e., what quality assurance program will be put place. For quality assurance, Maintenance Director/designe will review any findings daily, w subsequent corrective action a education for identified staff. Findings will be reporte the QA meeting monthly or un substantial compliance has be determined. Date of Compliance: 	vill t into the ee with and ed at		
					8-10-2022			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E2BG21 Facility ID: 000316 Page 63 of 63 If continuation sheet