STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BU	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  X3) DATE S  COMPLI  09/07/2			ETED	
	ROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG E 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg		eparedness Survey was ndiana Department of Health in 2 CFR 483.73.	E 00	00			
	Survey Date: 09/0	7/23					
	Facility Number: 0 Provider Number: 100	155491					
	Care of Connersvil compliance with E Requirements for M	Preparedness survey, Majestic lle was found in substantial mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR					
	The facility has 16 the survey, the cen	6 certified beds. At the time of sus was 96.					
	Quality Review co	mpleted on 09/11/23					
E 0025 SS=C Bldg	482.15(b)(7), 483 485.625(b)(7), 48 Arrangement with §403.748(b)(7), § (7), §460.84(b)(8	(418.113(b)(5), §441.184(b) (3), §482.15(b)(7), §483.73(b) (7), §485.625(b)(7),					
	must develop and preparedness pol on the emergence (a) of this section	procedures. The [facilities] If implement emergency licies and procedures, based by plan set forth in paragraph by its in the section, and the					

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

TITLE

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: ICQ521 Facility ID: 000316 If continuation sheet

(X6) DATE

PRINTED: 11/08/2023

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES					ORM APPROVED AB 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 09/07/2023	
	PROVIDER OR SUPPLIE		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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	section. The police be reviewed and years [annually for minimum, the poladdress the followard for the police of the police of the police of the procedures. (7) [arrangements with other providers to followard for the procedures of the providers to receive followard for the police fo	lan at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a icies and procedures must wing:]  It §418.113(b), PRFTs at spitals at §482.15(b), and §483.73(b):] Policies and or (5)] The development of the other [facilities] [and] or receive patients in the event essation of operations to cinuity of services to facility  In at §486.625(b), CMHCs at estate and procedures. (7) [or elopment of arrangements ess] [or] other providers to an the event of limitations or rations to maintain the ices to facility patients.  §403.748(b):] Policies and the development of the other RNHCls and other ive patients in the event of sation of operations to				

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

maintain the continuity of non-medical

and procedures include the development of

providers to receive residents in the event of

Based on record review and interview, the facility

failed to ensure emergency preparedness policies

arrangements with other LTC facilities and other

limitations or cessation of operations to maintain

services to RNHCI patients.

Event ID:

ICQ521

E 0025

Facility ID: 000316

If continuation sheet

Administrator/Designee ensured

the facility had a signed transfer

effective no later than 09/26/2023.

The facility has a signed transfer

agreement with heritage house

agreement with heritage house

Page 2 of 42

09/26/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			<del></del>	COMPL	
		155491	B. WI	_		09/07/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MA IESTI	C CARE OF CONN	JFRSVII I F			5TH STREET ERSVILLE, IN 47331		
					INOVILLE, IIV 47001		Г
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	DATE
		rvices to LTC residents in			this was completed by 09/26/2	2023	
	accordance with 42	CFR 483.73(b)(7). This			On 09/11/2023 the facility		
	deficient practice co	ould affect all occupants.			administrator educated the		
					maintenance director regardin	g the	
	Findings include:  Based on record review and interview with the				regulation of having a signed		
					transfer agreement with anoth	er	
		and Maintenance Director from			facility in case of emergency.  Administrator/ Designee will a	udit	
		09/07/23 between 10:10 a.m.			transfer agreement monthly x		
	•	lopment of arrangements with			ensure a signed and current		
	other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review.  Language in the documentation provided				transfer agreement with anoth	er	
					facility in case of emergencies		
					obtain new transfer agreemen		
		cumentation provided to of the facility to have such			upon administrator turnover, the	nen	
		er current signed specific			as determined by the QAA Committee.		
	-	ner facilities were not available			Committee.		
	-	stated that this was something					
		was working to provide each					
	facility.						
	T1 C 1:	i Iid- dh - Edi					
		viewed with the Executive of discovery and again at the					
		n the Executive Director, and					
		for from another facility					
	present.	•					
						ļ	
E 0037		6.54(d)(1), 418.113(d)(1),					
SS=C Bldg		2.15(d)(1), 483.475(d)(1),					
ыug		102(d)(1), 485.625(d)(1), 727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 491						
	EP Training Progra						
	• •	416.54(d)(1), §418.113(d)(1),					
	. , , , ,	460.84(d)(1), §482.15(d)(1),					
	. , , , ,	33.475(d)(1), §484.102(d)(1),					
	- , , , , -	85.625(d)(1), §485.727(d)					
	(1), §485.920(d)(1	), §486.360(d)(1),					
	§491.12(d)(1).						

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 3 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	
		155491	B. WI	NG		09/07/	2023
NAME OF P	DROWNER OF GURPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER	(		1029 E	5TH STREET		
MAJEST	IC CARE OF CONN	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)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DETERNO!)		DATE
		\$403.748, ASCs at §416.54,					
		.15, ICF/IIDs at §483.475,					
	HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]  (1) Training program. The [facility] must do all of the following:						
	(i) Initial training in emergency preparedness						
	(i) initial training in emergency preparedness policies and procedures to all new and						
	existing staff, individuals providing services						
	under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency						
	preparedness trai						
	(iv) Demonstrate s	staff knowledge of					
	emergency proced	dures.					
	(v) If the emergen	cy preparedness policies					
	and procedures a	re significantly updated, the					
	[facility] must cond	duct training on the					
	updated policies a	and procedures.					
	*[For Hospices at	§418.113(d):] (1) Training.					
		do all of the following:					
		n emergency preparedness					
	. , ,	edures to all new and					
	existing hospice e	mployees, and individuals					
	providing services	under arrangement,					
	consistent with the	eir expected roles.					
	(ii) Demonstrate s	taff knowledge of					
	emergency proced						
	l ' '	gency preparedness training					
	at least every 2 ye						
	l ` '	view and rehearse its					
		redness plan with hospice					
		ling nonemployee staff),					
	1	asis placed on carrying out					
	<u> </u>	ecessary to protect patients					
	and others.						

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 4 of 42

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN		<del></del>	COMPL		
		155491	B. WING			09/07/		
			O.T.	PET A	DDDESS SITY STATE TIP SOD			
NAME OF P	ROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP COD 5TH STREET			
MAJEST	IC CADE OF CONIN	JEDSVII I E						
IVIAJEST	IC CARE OF CONN	NENGVILLE		JININE	RSVILLE, IN 47331			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE	
	(v) Maintain docur	mentation of all emergency						
	preparedness trai							
		ncy preparedness policies						
		re significantly updated, the						
		duct training on the						
	updated policies a	and						
	*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the							
		TF must do all of the						
	following:							
	.,	n emergency preparedness						
	policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers,							
	•							
		eir expected roles.						
	, ,	ning, provide emergency						
		ning every 2 years.						
		staff knowledge of						
	emergency proced							
	preparedness trai	mentation of all emergency						
		cy preparedness policies						
	` '	re significantly updated, the						
		ict training on the updated						
	policies and proce	- · · · · · · · · · · · · · · · · · · ·						
	policies and proce	dures.						
	*IFor PACF at 846	60.84(d):] (1) The PACE						
	-	do all of the following:						
	-	n emergency preparedness						
	.,	edures to all new and						
	· ·	viduals providing on-site						
	•	rangement, contractors,						
		olunteers, consistent with						
	their expected role	•						
	· ·	ency preparedness training						
	at least every 2 ye	- · · · ·						
		staff knowledge of						
		dures, including informing						
		,	1				I	

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

participants of what to do, where to go, and

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet Page 5 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/07/2023		
	ROVIDER OR SUPPLIER		<u> </u>	1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	·	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC BLAN 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 APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL	DATE
	(iv) Maintain docu (v) If the emerger and procedures and PACE must condu policies and proce *[For LTC Facilities	n case of an emergency. mentation of all training. ncy preparedness policies re significantly updated, the act training on the updated edures. es at §483.73(d):] (1) The LTC facility must do all					
	of the following: (i) Initial training in emergency preparedness policies and procedures to all new and						
		edures to all new and viduals providing services					
	under arrangement, and volunteers, consistent with their expected role.						
	. ,	ency preparedness training					
	at least annually.						
	, ,	mentation of all emergency					
	preparedness trail	_					
	(iv) Demonstrate s emergency proces	_					
	emergency proced	dules.					
	*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:						
	, ,	raining in emergency cies and procedures to all					
		staff, individuals providing					
	•	rangement, and volunteers,					
	consistent with the	•					
		ency preparedness training					
	at least every 2 ye	ears.					
	(iii) Maintain docu	mentation of the training.					
	(iv) Demonstrate s	_					
		dures. All new personnel					
		and assigned specific					
		garding the CORF's					
		vithin 2 weeks of their first					
	•	ning program must include					
		ocation and use of alarm					
	systems and signa	ais and firefighting					

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 6 of 42

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155491		A. BUILDING B. WING	onstruction 	COMPLETED 09/07/2023		
	PROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP CO 5TH STREET ERSVILLE, IN 47331	D	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG	equipment.  (v) If the emerger and procedures are CORF must condupolicies and procedures are Torong and procedures are program. The CAR following:  (i) Initial training in policies and procedures and procedures and extire protection, and who for patients, person prevention, and conduct arrangement consistent with the provide emergency procedures are CAH must conduct policies and procedures are CAH must conduct policies and procedures are procedures to all result individuals providing arrangement, and their expected roles.	ncy preparedness policies re significantly updated, the act training on the updated adures.  35.625(d):] (1) Training the must do all of the aremargency preparedness adures, including prompt anguishing of fires, are necessary, evacuation and, and guests, fire properation with firefighting porities, to all new and viduals providing services at, and volunteers, are expected roles. The preparedness training areas.  The mentation of the training areas.  The significantly updated, the attraining on the updated adures.  1485.920(d):] (1) Training.  159.000000000000000000000000000000000000	TAG	DEFICIENCY		DATE
	must demonstrate	staff knowledge of dures. Thereafter, the				

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 7 of 42

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.  Findings include:  Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., there was no documentation	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155491		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/07/2023	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  preparedness training at least every 2 years. Based on record review and interview with the Executive Director and Maintenance Director from another facility on 99/07/23 between 10:10 a.m. and 1:20 p.m., there was no documentation  prepared Rescuration of all procedures are significantly updated. The Executive Director and Maintenance Director from another facility on 99/07/23 between 10:10 a.m. and 1:20 p.m., there was no documentation					1029 E 5TH STREET			
Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.  Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., there was no documentation	PREFIX	(EACH DEFICIEN REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDERS PLAN OF CORRECTION PREFIX GEACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION
available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and or for existing staff. Based on an interview at the time of records review, the ED searched during the survey and returned stating that the documentation did not exist.  The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present.		Based on record re failed to ensure sta preparedness polici ICF/IID facility mu Initial training in en and procedures to a individuals providi and volunteers, cor roles; (ii) Provide et training at least eve documentation of a training; (iv) Democ emergency procedure preparedness polici significantly update training on the update accordance with 42 deficient practice of the state	view and interview, the facility ff were trained in emergency ies and procedures. The ast do all of the following: (i) mergency preparedness policies all new and existing staff, ing services under arrangement, insistent with their expected emergency preparedness ery two years; (iii) Maintain all emergency preparedness constrate staff knowledge of ares; (v) If the emergency ies and procedures are ed, the facility must conduct ated policies and procedures in a CFR 483.475(d) (1). This could affect all occupants.  View and interview with the and Maintenance Director from 09/07/23 between 10:10 a.m. is was no documentation in to indicate all facility staff emonstrate knowledge of the edness Program (EPP) initially in for existing staff. Based on an ine of records review, the ED is survey and returned stating tion did not exist.  Viewed with the Executive is of discovery and again at the in the Executive Director, and	E 00	037	ensured that facility staff were educated on the Emergency Preparedness Program (EPP) later than 09/26/2023. The facility has educated staff the Emergency Preparedness Program. This was completed 09/26/2023. On 09/11/2023 the facility administrator educated the maintenance director regardin regulation of having staff education on the emergency preparedness plan.  Administrator/ Designee audit education on EPP monthly x 3 ensure staff are educated on Ethern as determined by the QA	on of on d by  g the cated ess  g to EPP,	09/26/2023

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

Event ID:

ICQ521 Facility ID: 000316

If continuation sheet Page 8 of 42

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  09/07/2023	
	PROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
K 0000							
Bldg. 01	Licensure Survey Department of Head 483.90(a).	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0	000			
	Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370  At this Life Safety Code survey, Majestic Care of Connersville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2.						
	the East Building ( which were detern construction and fi has a fire alarm sy the corridors and s The facility has a c census of 96 at the Rooms 401 - 410 v survey as the facili	ted of two, one story buildings, (2) and the West Building (1), nined to be of Type V (111) ally sprinkled. Each building stem with smoke detection in paces open to the corridor. capacity of 166 and had a time of this survey. Resident were not surveyed as part of this ity was experiencing a COVID and isolated that hallway.					
		sidents have customary access I all areas providing facility aklered.					
	Quality Review co	ompleted on 09/11/23					

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 9 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPL	ETED
		155491	B. WIN	IG		09/07/	/2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
					1		Т
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY		DATE
K 0271	NFPA 101						
SS=E	Discharge from Ex						
Bldg. 01	Discharge from Ex						
	_	rranged in accordance with					
	•	rel walking surface meeting					
	-	.1.7 with respect to					
	changes in elevation and shall be maintained						
	free of obstructions. Additionally, the exit						
	discharge shall be a hard packed all-weather travel surface.						
	18.2.7, 19.2.7 Based on observation and interview, the facility			71	   Maintenance Director/ Design	00	09/26/2023
		8 exit discharges had a level	K 02	/1	ensured that the 3 exits leading		09/26/2023
walking surface, were free of obs		_			the courtyard have a all-weath	•	
	-	packed all-weather travel			travel surface leading to a part		
	surface in accordance with CMS Survey and				lot no later than 10/15/2023.	Mily	
		05-38. This deficient practice			Maintenance Director/ Design	ee	
		lents and staff in the East			has ensured that the 3 exit lea		
	building.				the courtyard have an all weat	•	
	C				travel surface leading to a parl		
	Findings include:				lot. This was completed by 10/15/2023	J	
	Based on observation	ons and interviews during a			On 09/11/2023 the facility		
		with the Executive Director and			administrator educated the		
	Maintenance directo	or from another facility on			maintenance director regardin	g the	
	09/07/23 between 1	:20 p.m. and 4:50 p.m. the (1)			regulation stating all discharge	es	
	300 Hall exit near R	R#301, (2) the Kitchen Exit to			from exits must have a all wea	ıther	
	the outside and (3) t	he 100 & 200 Hall dining area			travel surface leading to a part	king	
		into the courtyard which was			lot or public access.		
		ing area. The aforementioned			Maintenance Director/ Design		
	•	we a hard packed all-weather			will audit the building discharg		
		ng to a parking lot or to the			from exit for all weather travel		
	•	artyard was surrounded by			surface leading to a parking lo		
		ne ED stated that at one point			public access point monthly x		
		ed "Not An Exit" but the			ensure discharges from exit a		
	-	Formed during a Fire Marshal			proper. Then as determined b	у	
		gns needed to be present and			QAA committee.		
		ded to be exits. The ED was			Requesting construction waive		
	exits.	nentioned exits were required			due to earliest date for concre 10/15/23.	ie is	
	CAILS.				10/15/23.		

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

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		 JILDING	nstruction 01	(X3) DATE COMPL <b>09/07</b> /	ETED	
	PROVIDER OR SUPPLIER		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	The finding was acl Director and Mainton facility at the time of exit conference with Maintenance Direct present.  3.1-19(b)  NFPA 101  Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-ho (with 3/4 hour fire automatic fire extinaccordance with 8 approved automatic option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.  Describe the floor hazardous areas to REMARKS.  19.3.2.1, 19.3.5.9  Area  Separation  a. Boiler and Fuel-b. Laundries (large	enance Director from another of discovery and again at the in the Executive Director and for from another facility  - Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an inguishing system in 3.7.1 or 19.3.5.9. When the sic fire extinguishing system is a areas shall be separated by smoke resisting rs in accordance with 8.4.	TAG	DEFICIENCY		DATE
	· ·	poms (exceeding 64				

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 11 of 42

i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155491	B. W	ING		09/07	/2023
NAME OF	PROVIDER OR SUPPLIER	<del></del>			ADDRESS, CITY, STATE, ZIP COD		
					5TH STREET		
MAJEST	TIC CARE OF CONN	NEKSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(exceeding 64 gal	orage Rooms/Spaces					
	(over 50 square fe	·					
	g. Laboratories (if classified as Severe Hazard - see K322)						
	1	on and interview, the facility	K 0	321	Maintenance Director/ Design	iee	09/26/2023
		f over 10 hazardous area doors,	0		ensured that storage rooms w		
	such as storage room	m, was provided with a			greater than 50 square feet th		
	properly working se	elf-closing device. This			contain combustible items have		
	_	ould affect more than 5			self closure with a door that		
	·	s staff and visitors in the 300			latches into its frame no later	than	
	Hall.				09/26/2023.		
					Maintenance Director/ Design		
	Findings include:				ensured that storage rooms w		
	Based on observation	ons and interviews during a			greater than 50 square feet the contain combustible items have		
		with the Executive Director and			self closure with a door that	vea	
		tor from another facility on			latches into its frame. This wa	as	
		:20 p.m. and 4:50 p.m. the 300			completed by 09/26/2023.	40	
		oom, greater than 50 square			On 09/11/2023 the facility		
		imber of combustible items,			administrator educated the		
		lboard boxes along with over			maintenance director regardir	ng the	
	14 paint cans. The	corridor door this mechanical			regulation stating that all stora		
		elf-close and latch into the			rooms with greater than 50 so	quare	
	door frame.				feet that contain combustible		
					items must have a self closure	-	
		knowledged by the Executive			with a door that latches into it	s	
		enance Director from another			frame.		
		of discovery and again at the hthe Executive Director and			Maintenance Director/ Design		
		tor from another facility			will audit the building for storal rooms that are greater than 5	-	
	present.	tor from another facility			square feet with combustible	U	
	present.				items, for doors with self closu	ıres	
	3.1-19(b)				that latch into its frame. This		
					audit will be completed weekl	v x	
					4, and then as determined by	•	
					QAA committee.		
K 0363	NFPA 101						
SS=E	Corridor - Doors				1		

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		JILDING	nstruction 01	(X3) DATE COMPI 09/07	LETED	
	PROVIDER OR SUPPLIER		1029 E	DDRESS, CITY, STATE, ZIP COD 5TH STREET RSVILLE, 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 F	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
Bldg. 01	Corridor - Doors	ESC ISENTI TING IN ORDERTOR	1110			DATE
Blug. 01	_	corridor openings in other				
		losures of vertical openings,				
	· ·	s areas resist the passage				
		made of 1 3/4 inch				
		wood or other material				
		ng fire for at least 20				
	•	fully sprinklered smoke				
		e only required to resist the				
	1	e. Corridor doors and doors				
	to rooms containing					
		rials have positive latching				
		atches are prohibited by				
		hese requirements do not				
	1	spaces that do not contain				
	flammable or com					
	Clearance betwee	en bottom of door and floor				
		ceeding 1 inch. Powered				
	_	vith 7.2.1.9 are permissible				
		device capable of keeping				
	the door closed wi	hen a force of 5 lbf is				
	applied. There is	no impediment to the				
	closing of the door	rs. Hold open devices that				
	release when the	door is pushed or pulled are				
	permitted. Nonrate	ed protective plates of				
	unlimited height a	re permitted. Dutch doors				
	meeting 19.3.6.3.6	6 are permitted. Door				
	frames shall be lal	beled and made of steel or				
		compliance with 8.3,				
	unless the smoke	•				
	1 -	fire window assemblies are				
		n sprinklered compartments				
		ctions in area or fire				
		s or frames in window				
	assemblies.					
		Parts 403, 418, 460, 482,				
	483, and 485					
		S details of doors such as				
	fire protection ratir	ngs, automatics closing				

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 13 of 42

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G <u>01</u>	(X3) DATE SURVEY  COMPLETED  09/07/2023		
	PROVIDER OR SUPPLIER		1029	EET ADDRESS, CITY, STATE, ZIP COD 9 E 5TH STREET NNERSVILLE, IN 47331	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED CORRECTION OF THE APPROPRIED CORRECTI	LD BE	(X5) COMPLETION DATE
	failed to ensure all dimpediment to closi frame and would re This deficient pract residents.  Findings include:  Based on observation to the facility was Maintenance Direct 09/07/23 between 1 following corridor to latch positively inframes:  a) Pantry Corridor b) Resident Room:  The finding was act Director and Maintenance Maintenance Maintenance with the time of exit conference with		K 0363	Maintenance Director/ De will ensure that doors that latch into their frame will on 09/26/2023.  Maintenance Director/ De ensured that doors latche positively into their respect frames. This was complet 09/26/2023  On 09/11/2023 the facility administrator educated the maintenance director regargulation that requires delatch positively into their respective frames.  Maintenance Director/ De will audit doors weekly x 4 ensure they latch positive their respective frames.	t do not do so by esignee d ctive eted by e arding the cors to esignee 4 to	09/26/2023
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers should be parriers shall be p	Iding Spaces - Smoke Iding Spaces - Smoke on nall be constructed to a tance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required				

STATEMEN	T 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		09/07/	/2023
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN 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
	systems where an is installed for smo to the smoke barri 19.3.7.3, 8.6.7.1(1	)					
	-	hanical smoke control					
	system in REMAR Based on observation failed to ensure all shall were protected resistance of each standard failed to ensure all shall were protected resistance of each standard failed to each standard failed fail	on and interview, the facility smoke barriers walls in the 300 to maintain the smoke moke barrier. LSC Section noke barriers to be constructed LSC Section 8.5 and shall have fire resistive rating. LSC three smoke barriers to be outside wall to an outside of a floor, or from a smoke barrier or by use of a combination university penetrations for cables, so, pipes, tubes, vents, wires, accommodate electrical, and, and communications rough a wall, floor, or only constructed as a smoke the ceiling membrane of the oke barrier assembly, shall be an or material capable of tement of smoke. This deficient to tstaff and at least 6 residents	K 0.	372	Maintenance Director/ Designation will ensure that walls do not have holes that cause walls to allow passage of smoke no later that 09/26/2023.  Maintenance Director/ Designation ensured that walls do not have holes that cause walls to allow passage of smoke. This was completed by 09/26/2023.  On 09/11/2023 the facility administrator educated the maintenance director regarding regulation that requires walls to allow the passage of smoke.  Maintenance director/ Designation walls to allow the passage of smoke.  Maintenance director/ Designation walls weekly*4 and then as determine by QAA committee.	g the	09/26/2023
	Findings include:						
	tour of the facility v Maintenance Direct 09/07/23 between 1 Hall Med Supply C sealed and would no	ons and interviews during a with the Executive Director and for from another facility on :20 p.m. and 4:50 p.m. the 300 loset wall was not completely of resist the passage of smoke.					

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet Page 15 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
		155491	B. WING			09/07/	2023
				TDEET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				5TH STREET		
MAJEST	IC CARE OF CONN	IERSVILLE	CONNERSVILLE, 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	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	`AG	DEFICIENCY)	-	DATE
	which was next to a	resident room.					
	Director and Mainte facility at the time of exit conference with	knowledged by the Executive enance Director from another of discovery and again at the name that the name or from another facility					
K 0761 SS=E Bldg. 01							
	Based on observation, records review, and interview; the facility failed to ensure annual inspection and testing of the East Wing fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:		K 076	1	On behalf of Majestic Care of Connersville ("Facility"), and in accordance with Indiana Administrative Code Rule and C.F.R. §488.331, we respectfurequest a face to face Informa Dispute Resolution with regardings K 761 Maintenance, Inspection & Testing - Doors deficiency.  The K761 Maintenance, Inspe & Testing - Doors, deficiency should be deleted. The deficient stated:  Based on record review and interview with the Executive Director and Maintenance Director and Helpide documentation of the facility's annual inspection of the facility's annual inspection of the East Building fire door assemblies was available for review, however the reports we not dated, and it was unclear	42 Illy I to ction cited ency ector 23 tion on	09/26/2023

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet Page 16 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155491	B. W			09/07/	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
NAA 1505	10 0 4 DE 0E 00 N	IEDOVIII I			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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(1) No open holes or breaks exist in surfaces of				when the inspections were		
	either the door or frame.				performed. The documentatio	n for	
	(2) Glazing, vision light frames, and glazing beads				the West building was dated		
	are intact and securely fastened in place, if so				08/11/23. Based on observati	on	
	equipped.				during the tour fire door		
	(3) The door, frame, hinges, hardware, and				assemblies in the East Buildir	-	
	noncombustible threshold are secured, aligned,				were observed. Based on inte		
	_	er with no visible signs of			at the time of records review a		
	damage.				observation, the ED acknowle	_	
	(4) No parts are mis	_			the annual fire door inspection		
	` ′	do not exceed clearances			the East building were not dat	:ed	
	listed in 4.8.4 and 6				and it was unclear when the		
		device is operational; that is,			inspections occurred.		
		pletely closes when operated			Furthermore, documentation f	or	
	from the full open p				regular monthly general door		
	1 ' '	is installed, the inactive leaf			inspections was provided, how		
	closes before the ac				the documentation did not inc		
		are operates and secures the			the required information neces		
	door when it is in th	-			for an annual fire door assem	bly	
		vare items that interfere or			inspection.		
		re not installed on the door or			l <u></u>		
	frame.	*			The surveyor erred in citing the		
	, ,	ications to the door assembly			deficiency and is being arbitra	-	
	_	ed that void the label.			and capricious for stating that		
		edge seals, where required, are			there is some question of whe		
		their presence and integrity.			the fire door inspections for w	est	
		ice could affect all residents in			building was completed. The		
	the East Building.				surveyor confirms all of the		
	E' 1' ' 1 1				inspections were completed a		
	Findings include:				that the east building was don	ie on	
	Rosed on magaind may	view and interview with the			August 11, 2023.		
					The fire deer increations wer		
	Executive Director and Maintenance Director from				The fire door inspections wer	<del>C</del>	
	another facility on 09/07/23 between 10:10 a.m.				completed by the facility's Maintenance director, the reg	ional	
	and 1:20 p.m., the provided documentation of the				director of Plant Operations a		
	facility's annual inspection for the East Building				the corporate LSC consultant		
	fire door assemblies was available for review, however the reports were not dated, and it was				August 11, 2023 (and as indic		
	_	spections were performed.			on the facility layout drawings		
		for the West building was					
	I He documentation	ioi die west building was	1		which identify all of the fire do	UIS	I

ICQ521

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
		155491	B. WING	i		09/07/	2023
			S	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			5TH STREET		
MAJEST	IC CARE OF CONN	NERSVILLE			ERSVILLE, IN 47331		
					,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
		sed on observation during the			that are to be inspected).		
		ablies in the East Building were			The area was a most local and a standard		
	observed. Based on interview at the time of records review and observation, the ED acknowledged the annual fire door inspections for				There was not lack of a date of	on	
					the entire packet of door	th.	
		ere not dated and it was			inspections which included bo		
	unclear when the in				the West and East building. Mode one of the individual	iay	
	unclear when the in	spections occurred.			inspections forms was not date	od	
	The finding was rev	viewed with the Executive			but the entire packet contains		
	_	of discovery and again at the			life safety drawings for the two		
		h the Executive Director, and			buildings and more than 30	<u>'</u>	
		tor from another facility			individual fire door inspections		
	present.	10111 411011141 1441114			marriadar mo door mopootione	•	
	1				All of the inspections along wi	ith	
	3.1-19(b)				notes, scribbles, and commen		
	,				on the three-dozen individual t		
					door inspections are dated and	d all	
					use the same pen and handwi		
					(facility Maintenance Supervis	or).	
					The surveyors acknowledge th	nat	
					there are dates on most of the		
					documents just not one from t	ne	
					West building, but this does no	ot	
					invalidate the inspections and	for	
					the above stated reason the		
					deficiency should be deleted.		
					<b></b>		
					Maintenance Director/ Design		
					will ensure that annual fire dod		
					inspection is done timely. This	3	
					will be done no later than		
					09/26/2023		
					Maintenance Director/ Design		
					ensured that the annual fire do		
					inspection was completed time	•	
					This was done by 09/26/2023.		
					On 09/11/2023 the facility administrator educated the		
						a the	
			1		maintenance director regardin	y u ie	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155491	B. W	ING		09/07/	/2023
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					5TH STREET		
MAJESTI	IC CARE OF CONN	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(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		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
					regulation that requires annua	l fire	
					door inspection.	1 1110	
					door mapeonom.		
K 0000							
Bldg. 03							
3.00	A Life Safety Code	Recertification and State	K 0	000			
	_	vas conducted by the Indiana	100	000			
	•	Ith in accordance with 42 CFR					
	483.90(a).	in in accordance with 12 cl it					
	403.70(a).						
	Survey Date: 09/07	7/23					
	Burvey Bate. 09/0	1125					
	Facility Number: 0	000316					
	Provider Number:						
	AIM Number: 100						
	Anvi Number. 100	280370					
	At this Life Sefety	Code survey, Majestic Care of					
	-	ound not in compliance with					
	Requirements for P	_					
	_	-					
		l, 42 CFR Subpart 483.90(a),					
	-	re and the 2012 edition of the					
		ction Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
	Health Care Occup	ancies, and 410 IAC 16.2.					
	TEL C 1114	1 64 1 11					
	-	ed of two, one story buildings,					
		2) and the West Building (1),					
		ined to be of Type V (111)					
		lly sprinkled. Each building					
		tem with smoke detection in					
	-	paces open to the corridor.					
		apacity of 166 and had a					
		time of this survey. Resident					
		vere not surveyed as part of this					
	_	y was experiencing a COVID					
	19 outbreak and ha	d isolated that hallway.					
		idents have customary access					
	were sprinkled and	all areas providing facility					

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet Page 19 of 42

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPI	
		155491	B. WI	ING		09/07	/2023
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	FROVIDER OR SUFFLIER				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	ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	services were sprin	klered.					
	Quality Review con						
K 0211	NFPA 101						
SS=E	Means of Egress	- General					
Bldg. 03	Means of Egress						
	1	ays, corridors, exit					
	discharges, exit lo	ocations, and accesses are					
	in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.						
	18.2.1, 19.2.1, 7.1.10.1						
		on and interview, the facility	K 0	211	Maintenance Director/ Design	00	09/26/2023
			K U	211	ensured that carts in the camp		09/20/2023
	failed to ensure 1 of over 6 corridor means of egresses were continuously maintained free of				had wheels no later than		
		19.2.3.4 (4) states projections			09/26/2023		
	into the required wi	idth shall be permitted for			The maintenance director/		
	wheeled equipment	, provided that all of the			designee has ensured that cal	rts in	
	following condition				the hallways have wheels. Th		
		uipment does not reduce the			was completed by 09/26/2023	i.	
		corridor width to less than 60			On 09/11/2023 the facility		
	in.(1525 mm).	c			administrator educated the		
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	occupancy fire safety plan and ldress the relocation of the			maintenance director regarding	•	
		during a fire or similar			regulation of having wheels or	1	
	emergency.	during a fire of similar			carts in the hallways.  Maintenance Director/ Design	00	
		ipment is limited to the			will audit carts in the hallway	00	
	following:	•			weekly x 4, then as determine	d by	
	i. Equipment in use	and carts in use			QAA Committee	,	
		ncy equipment not in use					
		ransport equipment					
	-	ice affects 15 residents in the					
	facility.						
	Findings include:						
	i maniga merude.		- 1		I		I

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

Based on observations and interview during a

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 20 of 42

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 S COMPL 09/07/	ETED	
	PROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP COE 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 03	Maintenance Direct 09/07/23 between 1 corridor near Reside stored in the corridor wheels allowing the during an emergence.  The finding was ack Director and Mainter facility at the time of exit conference with Maintenance Direct present.  3.1-19(b)  NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security ne used, only one loc permitted on each be made for the ra by: remote control locks or keys carri other such reliable staff at all times.	chowledged by the Executive chance Director from another of discovery and again at the athe Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for from another facility.  In the Executive Director and for fine facility.  In the Executive Director and for facility.  In the Execut				

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 21 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	03	COMPLE			
		155491	B. W	TNG	_	09/07/2	2023		
NAME OF P	DROWNER OF GURPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER	C.		1029 E	5TH STREET				
MAJEST	IC CARE OF CONN	IERSVILLE		CONNERSVILLE, 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 DEFICIENCY)	TE.	COMPLETION		
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE		
	-	king arrangements for the							
	1	e patient are used, all of							
		curity Locking requirements							
	_	addition, the locks must be							
		at fail safely so as to							
	· ·	of power to the device; the ed by a supervised							
		er system and the locked							
		by a complete smoke							
	1 '	or is constantly monitored							
	I	ation within the locked							
		the sprinkler and detection							
	l ' '	ged to unlock the doors							
	upon activation.								
	18.2.2.2.5.2, 19.2.	.2.2.5.2. TIA 12-4							
	DELAYED-EGRE								
	ARRANGEMENTS								
	Approved, listed d	lelayed-egress locking							
		in accordance with							
	7.2.1.6.1 shall be	permitted on door							
	assemblies servin	g low and ordinary hazard							
	contents in buildin	gs protected throughout by							
	an approved, supe	ervised automatic fire							
	detection system	or an approved, supervised							
	automatic sprinkle	er system.							
	18.2.2.2.4, 19.2.2.								
	ACCESS-CONTR								
	LOCKING ARRAN								
		l Egress Door assemblies							
		lance with 7.2.1.6.2 shall							
	be permitted.								
	18.2.2.2.4, 19.2.2.								
	ELEVATOR LOBE								
	LOCKING ARRAN								
	I	t access door locking in							
		7.2.1.6.3 shall be permitted							
		es in buildings protected							
		approved, supervised							
		ection system and an							
	approved, supervi	sed automatic sprinkler							

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet Page 22 of 42

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	LETED
		155491	B. W	ING		09/07/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	IO OADE OF OON	IEDOVII I E	1029 E 5TH STREET CONNERSVILLE, IN 47331				
MAJEST	IC CARE OF CONN	IERSVILLE		CONNE	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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	system.						
	18.2.2.2.4, 19.2.2.	2.4					
	1. Based on observ	ation and interview, the	K 0	222	Maintenance Director/ Design	ee	09/26/2023
	facility failed to ens	sure the means of egress			ensured that delayed egress of		
	through 3 of over 6	delayed egress locks was			in the facility have proper sign		
	readily accessible for	or all residents, staff, and			that reads "Push Until Alarm		
	visitors. LSC 7.2.1.	.6.1.(3) (4) states a readily			Sounds. Door can be opened	in 15	
		in letters not less than 1 in.			seconds" no later than		
	_	ot less than 1/8 in. (3.2 mm) in			09/26/2023. Maintenance		
		ontrasting background that			Director/ Designee also ensur	ed	
	reads as follows sha	all be located on the door leaf			that all exit doors with a code		
	adjacent to the relea	ase device in the direction of			posted could be opened using	that	
	egress: "PUSH UN	TIL ALARM SOUNDS. DOOR			code no later than 09/26/2023		
	CAN BE OPENED	IN 15 SECONDS".			The maintenance director/		
	This deficient practi	ice could affect 23 residents.			designee have ensured that a	II	
					delayed egress doors have pro		
	Findings include:				signage that reads "Push until	-	
	-				alarms sounds Door can be		
	Based on observation	ons and interviews during a			opened in 15 seconds" This v	vas	
	tour of the facility v	vith the Executive Director and			completed by 09/26/2023. Th		
	Maintenance Direct	or from another facility on			maintenance director/ designe		
	09/07/23 between 1	:20 p.m. and 4:50 p.m., the exit			has also ensured that all exit		
	door located near th	e activity's office was			doors with a code posted oper	n	
	provided with delay	red egress locks but lacked			using that code. This was		
	signage indicating t	he doors can be opened in 15			completed by 09/26/2023		
	seconds by pushing	on the door. Furthermore,			On 09/11/2023 the facility		
	other delayed egress	s doors throughout the facility			administrator educated the		
	were equipped with	homemade signage and not	1		maintenance director regardin	g the	
	the required readily	visible, durable sign in letters			regulation of having the prope	r	
	not less than 1 in. (2	25 mm) high and not less than			signage on delayed egress do	ors	
	1/8 in. (3.2 mm) in	stroke width on a contrasting			and the same regulation requi	ring	
	background that rea	ds as follows: "PUSH UNTIL			exit doors to have a posted co	de	
	ALARM SOUNDS	. DOOR CAN BE OPENED IN			that can open the doors.		
	15 SECONDS."				Maintenance Director/ Design	ee	
					will audit the signage on delay	red	
	The finding was acknowledged by the Executive				egress doors and the ability to	)	
	Director and Mainte	enance Director from another			open the doors using the post	ed	
	facility at the time of	of discovery and again at the			code. Weekly x 4, and then a		
	exit conference with	n the Executive Director and			determined by QAA Committe	e.	
	Maintenance Direct	or from another facility					

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		ľ	UILDING	INSTRUCTION  03	(X3) DATE COMPI 09/07	LETED	
	ROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
mo	present.	CESC IDENTIFY THE INCIDENT TO		1110			DITTE
	present						
	3.1-19(b)						
	2. Based on observation and interview, the						
		sure the means of egress					
	through 2 of over 8 exits were readily accessible						
	for residents without a clinical diagnosis requiring						
		measures. Doors within a					
	required means of egress shall not be equipped						
	with a latch or lock that requires the use of a tool						
	or key from the egress side unless otherwise						
	permitted by LSC 1	9.2.2.2.4. Door-locking					
		be permitted in accordance					
		This deficient practice could					
		and visitors if needing to exit					
	the facility.						
	Findings include:						
	Based on observation	ons and interview during a					
	tour of the facility v	with the Executive Director and					
	Maintenance Direct	tor from another facility on					
		:20 p.m. and 4:50 p.m., the (1)					
		ctivities office and (2) the					
		each marked as facility exits,					
		locked and could be opened by					
		t code but the code posted was					
	incorrect and did no	ot release and open the doors.					
	The finding was acl	knowledged by the Executive					
		enance Director from another					
	•	of discovery and again at the					
		h the Executive Director and					
		tor from another facility					
	present.						
	3.1-19(b)						

Event ID: ICQ521 Facility ID: 000316 If continuation sheet Page 24 of 42

PRINTED: 11/08/2023 FORM APPROVED

STREFT ADDRESS, CITY, STATE, ZIP COD  DESTREMENT OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  MALESTIC CARE OF CONNERSVILLE  STREFT ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET  CONNERSVILLE, IN 47331  TAG  STREFT ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET  CONNERSVILLE, IN 47331  TAG  STREFT ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET  CONNERSVILLE, IN 47331  TAG  STREFT ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET  CONNERSVILLE, IN 47331  TAG  STREFT ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET  CONNERSVILLE, IN 47331  TAG  COMPLETION  DATE  TAG  OX35  NPPA 101  Alcohol Based Hand Rub Dispenser (ABHR)  Bidg, 03  Alcohol Based Hand Rub Dispenser (ABHR)  Alcohol Based Hand Rub Dispenser (ABHR)  Bidg, 03  Alcohol Based Hand Rub Dispenser (	ENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF CONNERSVILLE  SUMMARY STATEMENT OF DEFICIENCIE  GORPERS  TAG  SEGULATORY OR LSC IDENTIFYING INFORMATION  Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF CONNERSVILLE  (XA) ID  PRIFFIX  (RACH DEFICIENCY MUST BE PRECEDED BY BILL  TAG  REGILATORY OR ISC IDENTIFYING INFORMATION  (X325)  SS=E  Bidg, 03  NFPA 101  Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with  8,73.1, unless all conditions are met:  " Corridor is at least 6 feet wide  " Maximum individual dispenser capacity is  0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols  " Dispensers shall have a minimum of 4-foot horizontal spacing  " Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  " Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  " Dispensers vere carpeted floors are in sprinklered smoke compartments  " ABHR does not exceed 95 percent alcohol " Operation of the dispensers shall comply with Section 18.3.2.6 (11) or 19.3.2.6 (11)  " ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility flided to ensure 2 of over 20 alcohol-based hand samitizer dispensers were not installed over an ignition source. Within a 1-inch  (B) Above an ignition source within a 1-inch  STREET ADDRESS, CITY, STATE, 21P COD 1025 (CX)  DISCATING ARTHOR OF CARCHARY ARTHOR	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED	
MAJESTIC CARE OF CONNERSVILLE  MAJESTIC CARE OF CONNERSVILLE  SUMMARY STATEMENT OF DETICIENCE  PRETIX TAG  SUMMARY STATEMENT OF DETICIENCE  (EACH DETICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  ACO325  SS=E  Bildg. 03  Alchohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispens			155491	B. W	ING		09/07/	2023	
MAJESTIC CARE OF CONNERSVILLE  (X4) ID SUMMARY STATEMENT OF DEPICIENCIE PREFIX (RACH DEPICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OF LISC DEPINITY/NIG INFORMATION TAG REGULATORY OF LISC DEPINITY OF COMPLETION DATE  TAG REGULATORY OF LISC DEPINITY OF COMPLETION TAG REGULATORY OF LISC DEPINITY OF COMPLETION DATE  TAG REGULATORY OF LISC DEPINITY OF COMPLETION DATE  TAG REGULATORY OF COMPLETION DATE TAG REGULATORY OF COMPLETION DATE TAG REGULATORY OF COMPLETION DATE TAG REGULATORY OF COMPLETION DATE TAG REGULATORY OF COMPLETION DATE TAG REGULATORY OF COMPLETION DATE TAG REG			L		STREET A	ADDRESS, CITY, STATE, ZIP COD			
SUMMARY STATEMENT OF DEFICIENCIE PREFIX (RACID DEFICENCY MUST BE PRECODED BY FULL AGA (NO325 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRa are protected in accordance with 8.7.3.1, unless all conditions are met: 'Corridor is at least 6 feet wide 'Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols 'Dispensers shall have a minimum of 4-foot horizontal spacing 'Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment greater than 5 gallons complies with NFPA 30 'Dispensers are not installed within 1 inch of an ignition source 'Dispensers over carpeted floors are in sprinklered smoke compartments 'ABHR does not exceed 95 percent alcohol 'Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) 'ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. PFA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch	NAME OF F	PROVIDER OR SUPPLIEF	8		1029 E	5TH STREET			
PRETX TAG REGULATORY OR ISC IDENTIFYING INFORMATION TAG REGULATORY OR ISC IDENTIFYING INFORMATION REGULATORY OR ISC IDENTIFYING INFORMATION TAG REGULATORY OR INFORMATIO	MAJEST	IC CARE OF CONN	NERSVILLE		CONNE	ERSVILLE, IN 47331		<u> </u>	
TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  REQUILATORY OR LSC IDENTIFYING INFORMATION  REQUILATORY OR LSC IDENTIFYING INFORMATION  TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  REQUILATORY OR LSC IDENTIFYING INFORMATION  TAG  REQUILATORY OR LSC IDENTIFYING INFORMATION  REQUILATORY OR LSC IDENTIFY INFORMATION  TAG  REPARCHMENT  REQUILATORY OR LSC IDENTIFY INFORMATION  TAG  REPARCH SERVING  TAG  TORS  TA	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
RO325  NFPA 101  Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:  ' Corridor is at least 6 feet wide  ' Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols ' Dispensers shall have a minimum of 4-foot horizontal spacing ' Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room ' Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 ' Dispensers are not installed within 1 inch of an ignition source ' Dispensers over carpeted floors are in sprinklered smoke compartments ' ABHR does not exceed 95 percent alcohol ' Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) ' ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
Alcohol Based Hand Rub Dispenser (ABHR) BAIRS are protected in accordance with 8.7.3.1, unless all conditions are met:  * Corridor is at least 6 feet wide  * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols  * Dispensers shall have a minimum of 4-foot horizontal spacing  * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand samitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  K 0325  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets. This		REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
Bidg. 03 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch  K 0325  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This	K 0325	NFPA 101							
ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:  *Corridor is at least 6 feet wide  *Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 acrosols  *Dispensers shall have a minimum of 4-foot horizontal spacing  *Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  *Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  *Dispensers are not installed within 1 inch of an ignition source  *Dispensers over carpeted floors are in sprinklered smoke compartments  *ABHR does not exceed 95 percent alcohol  *Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  *ABHR is protected against inapropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  *ABHR is aleast feet wide  *Maximum individual dispenser specifical out and 18 ounces of fluid or 13 feet of 19 gallons of fluid and 18 ounces of Level 1 acrosols  *Dispensers are not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch		Alcohol Based Ha	nd Rub Dispenser (ABHR)						
8.7.3.1, unless all conditions are met:  * Corridor is at least 6 feet wide  * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols  * Dispensers shall have a minimum of 4-foot horizontal spacing  * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  * Corridor is at least 6 feet wide * Maximum individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons of fluid or 135 ounces aerosol are used in a sanitizer dispenser shall one pictoriol pesignee ensured that hand sanitizers were not directly above electrical outlets. This	Bldg. 03	Alcohol Based Ha	nd Rub Dispenser (ABHR)						
* Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand santitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch		ABHRs are protect	cted in accordance with						
* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(1) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch  * Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets. This		8.7.3.1, unless all	conditions are met:						
0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch		* Corridor is at lea	st 6 feet wide						
and 18 ounces of Level 1 aerosols  * Dispensers shall have a minimum of 4-foot horizontal spacing  * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  and 18 expenses a minimum of 4-foot horizonts of fluid or 135 ounces atorage actorage actorage actorage cabinet, excluding on the storage cabinet, excluding on the s		* Maximum individ	dual dispenser capacity is						
* Dispensers shall have a minimum of 4-foot horizontal spacing  * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch		0.32 gallons (0.53	gallons in suites) of fluid						
horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch    Name   Nam		and 18 ounces of	Level 1 aerosols						
* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  * Not more than a single smoke compartment a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complete with NFPA 30  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		* Dispensers shal	I have a minimum of 4-foot						
fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch		horizontal spacing	]						
single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch     K 0325		* Not more than an aggregate of 10 gallons of							
cabinet, excluding one individual dispenser per room  * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch     Volume 1		fluid or 135 ounce	s aerosol are used in a						
per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch  K 0325  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		single smoke com	partment outside a storage						
* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  * Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch		cabinet, excluding	one individual dispenser						
greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch  Waintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		per room							
* Dispensers are not installed within 1 inch of an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		* Storage in a sing	gle smoke compartment						
* Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch  * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		-	lons complies with NFPA						
an ignition source  * Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch   ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This			not installed within 1 inch of						
* Dispensers over carpeted floors are in sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This									
sprinklered smoke compartments  * ABHR does not exceed 95 percent alcohol  * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  (b) Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This									
* ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  **COPTENTIAL TOP TOP SUBJECT OF SUBJECT OF TOP SUBJEC			•						
* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  **COPERTOR OF A 101 (1) or 19.3.2.6(11)  **COPERTOR OF A 103.2.6(11)  **COPERTOR OF A		l •	•						
with Section 18.3.2.6(11) or 19.3.2.6(11)  * ABHR is protected against inappropriate access  18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  (b) Waintenance Director/ Designee ensured that hand sanitizers were not later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This			•						
* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch   K 0325  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		· ·	· · · · · · · · · · · · · · · · · · ·						
access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  K 0325  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This			. ,						
18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  K 0325  Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		· ·	od agamot mappropriato						
460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  (b) Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This			42 CFR Parts 403 418						
Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  (b) Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This		l '							
failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This				K O	325	Maintenance Director/ Design	ee	09/26/2023	
sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  not directly above electrical outlets no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This				1.0	525			07/20/2023	
ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  no later than 09/26/2023.  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This									
states dispensers shall not be installed in the following locations:  (a) Above an ignition source within a 1-inch  Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This						1			
following locations:  (a) Above an ignition source within a 1-inch  ensured that hand sanitizers were not above electrical outlets. This		l -					ee		
(a) Above an ignition source within a 1-inch not above electrical outlets. This		_				_			
		_							

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

(b) To the side of an ignition source within a

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

On 09/11/2023 the facility

administrator educated the

Page 25 of 42

PRINTED: 11/08/2023

DEPARTMENT		FOR	RM APPROVED					
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>03</u>			COMPL	ETED	
		155491	B. WI	NG		09/07/	2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
TOTAL OF T	KO VIDEK OK SOI I EIEK			1029 E	5TH STREET			
MAJESTIC CARE OF CONNERSVILLE				CONNERSVILLE, IN 47331				
					·			
(V4) ID	CHMMADV	TATEMENT OF DEFICIENCIE	I	ID			(V5)	

MAJEST	ΓIC CARE OF CONNERSVILLE	CONNI	CONNERSVILLE, IN 47331			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 20 residents.  Findings include:  Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in (1) the dining room rear the bulletin board and (2) in the corridor between Resident Rooms 912 & 913. The Executive Director confirmed the alcohol-based hand sanitizer dispensers were installed on the wall directly above electrical outlets.  The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present.  3.1-19(b)		maintenance director regarding the regulation stating that hand sanitizers cant be directly above electrical outlets.  Maintenance Director/ Designee will audit the building for hand sanitizers directly above electrical outlets weekly x 4. Then as determined by QAA Committee.			
K 0346 SS=C Bldg. 03	NFPA 101 Fire Alarm System - Out of Service 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.					

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 26 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155491	B. WI	NG		09/07/	/2023
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			5TH STREET		
MA IEST	IC CARE OF CONN	NERSVII I E			ERSVILLE, IN 47331		
IVIAULUI	- CONT	4LI (OVILLE		CONNE	-100 VILLE, 114 7/301		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	9.6.1.6						
		view and interview, the facility	K 0.	346	On behalf of Majestic Care of		09/26/2023
	_	complete 1 of 1 written policy			Connersville ("Facility"), and ir	1	
	_	f residents indicating			accordance with Indiana		
	1 ~	llowed in the event the fire			Administrative Code Rule and		
		be placed out of service for			C.F.R. §488.331, we respectful		
	four hours or more in a twenty-four-hour period in				request a face to face Informa		
		SC, Section 9.6.1.6. This			Dispute Resolution with regard	d to	
	deficient practice at	ffects all occupants.			tags K 346 deficiency.		
					The K 346 Fire Alarm System		
	Findings include:				Out of Service, deficiency cite		
					should be deleted. The deficient	ency	
	Based on record review and interview with the				stated:		
		and Maintenance Director from					
	1	09/07/23 between 10:10 a.m.			The fire watch plan failed to		
	_	fire watch plan failed to include			include contacting the Indiana		
	_	ana State Department of Health			State Department of Health vi	a the	
	via the ISDH Gatev	-			ISDH Gateway link at		
		h.in.gov as the primary method			https://gateway.isdh.in.gov as	the	
		method when the ISDH			primary method or by the		
		rational by completing the			secondary method when the l		
		form and e-mailing it to			Gateway is nonoperational by		
		gov. Based on interview			completing the Incident Repor	ting	
		eview, the Executive Director			form and e-mailing it to		
	_	fire watch documentation			incidents@isdh.in.gov. Based		
	_	contact the Indiana State			interview during the record rev	/iew,	
	_	Ith at a phone number, and not			the Executive Director		
		way link or at the e-mail address			acknowledged the fire watch	d to	
		ED stated that this was an issue			documentation provided state	น เด	
		luring the survey no additional			contact the Indiana State		
	ire watch documer	ntation was provided.			Department of Health at a pho		
	The finding was	viewed with the Evecutive			number, and not via the ISDH		
	_	viewed with the Executive of discovery and again at the			Gateway link or at the e-mail		
		h the Executive Director, and			listed above.		
		tor from another facility			The surveyor arred in sitation	tho	
		ioi nom anomer facility			The surveyor erred in citating	uie	
	present.				facility at K 346 Fire Alarm	100	
	2 1 10(b)				System - Out of Service becau		
	3.1-19(b)				the there is no CMS, NFPA or		

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 27 of 42

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 11/08/2023
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09						
	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 09/07/2023	
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
140	REGULATORY	ESC IDENTIFYTHING INFORMATION	TAG	requires skilled nursing providers to specifically use a specific 'portal' or email addret to notify the Indiana Departmen Health. This 'portal' or email would the Indiana Departmen Health's preferred method but not the law.  NFPA 72, National Fire Alarm Signaling Code clearly states the service provider is respon for notifying the AHJ when an system is out of service for methan four hours and offers a liconsiderations that should be weighed if the building fire alar system is not functional. Furthermore, the NFPA 101, I Safety Code state that one of expected notifications may be licensing authority having jurisdiction but it does not requive a specific mode of the notification.  The facility as confirmed by the surveyor does include in the notification section of the Fire Alarm Outage — Fire Watch peand procedure the phone num	ess ent of  t of t is  n that esible y ore st of  arm  Life the e to a  uire	
				to the Indiana Department of Health which would be reason to notify of an engaged fire was For the above stated reason, deficiency K 346 should be deleted as the facility is clearl compliance having met the deleted.	nable atch. the y in	

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

of burden by including the contact

Page 28 of 42

	Γ OF HEALTH AND HU R MEDICARE & MEDIC					ED: 11/08/2023 M APPROVED NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SI COMPLE 09/07/2	TED
	PROVIDER OR SUPPLIEI		1029 E	ADDRESS, CITY, STATE, ZIP COD 5 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 APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
				information of the Indiana Department of Health in its Fire Watch Policy. Administrator/ Designee ensur that a fire watch plan was implemented that included the ISDH Gateway Link no late tha 09/26/2023 Administrator/ Designee ensur that the fire watch plan with IS Gateway link is implemented. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding regulation that requires the ISE Gateway Link to be listed as a primary or secondary method	red an red DH g the DH	

K 0353 SS=E Bldg. 03 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

ICQ521

Facility ID: 000316

communication.

Committee.

Maintenance Director/ Designee will audit the fire watch plan monthly x3 to ensure that the fire watch plan includes the gateway link as a primary and secondary method of communication and then as determined by the QAA

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	03	COMPLETED	
		155491	B. W	ING		09/07	/2023
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA	.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMAF	RKS information on					
	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility						
			K 0	252	   Maintenance Director/ Design	00	09/26/2023
		f 2 sprinkler systems was	KU	333	ensured that there are two spa		09/20/2023
		sprinklers, a spare sprinkler			sprinkler heads of every type		
	cabinet and a sprinkler wrench on the premises.				sprinkler head represented in		
		for the Inspection, Testing,			facility no later than 09/26/202	23	
		Water-Based Fire Protection			Maintenance Director/ Design		
	-	ion, Section 5.4.1.4 states a			ensured that there are two spa	ares	
		nklers (never fewer than six) on the premises so that any			of every sprinkler head	:_	
		been operated or damaged in			represented in the facility. Th was completed by 09/26/2023		
	-	mptly replaced. The sprinklers			On 09/11/2023 the facility	•	
		the types and temperature			administrator educated the		
	ratings of the sprink	tlers on the property. The			maintenance director regardin	g the	
	-	cept in a cabinet located where			regulation that requires there	to be	
	-	which they are subjected will at			2 spares of every type of sprir	nkler	
		degrees Fahrenheit. A special			head in the facility.		
	•	all be provided and kept in the nthe removal and installation			Maintenance Director/ Design		
		deficient practice could affect			will audit the spare sprinkler h monthly x 3 and then as	<del>c</del> aus	
	-	ff in the West Building.			determined by the QAA		
	Findings include:	č			committee.		
	Decedes 1 C	1 !					
		ons and interview during a with the Executive Director and					
		for from another facility on					
		:20 p.m. and 4:50 p.m., there					
		kler cabinet in the riser room					
		e sprinklers and the provided					
	-	ls did not include 2 of every					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	03	COMPLETED
		155491	B. WING		09/07/2023
	ROVIDER OR SUPPLIER		1029	ET ADDRESS, CITY, STATE, ZIP COD E 5TH STREET NERSVILLE, IN 47331	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
K 0354 SS=C Bldg. 03	facility. The Mainter facility agreed that is meet the requirement provided did not cook kind represented in the finding was ach Director and Mainter facility at the time of exit conference with Maintenance Direct present.  3.1-19(b)  NFPA 101  Sprinkler System - Sprinkler System - Where the sprinkler system - Where the sprinkler extent and duration been determined, are inspected and recommendations management or deand the fire depart having jurisdiction the sprinkler system than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1, Based on record revent the automatic placed out-of-service 24-hour period in according to the sprinkler system of the service of th	cnowledged by the Executive enance Director from another of discovery and again at the in the Executive Director and for from another facility  - Out of Service - Out of Service - Out of Service er system is impaired, the in of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, timent and other authorities have been notified. Where im is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 0354	On behalf of Majestic Care of Connersville ("Facility"), and is accordance with Indiana Administrative Code Rule and C.F.R. §488.331, we respectively request a face to face Information.	d 42 fully

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155491	B. W	ING		09/07	/2023
				_	_		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					5TH STREET		
MAJEST	IC CARE OF CONN	IERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
IAG			+	IAG	Dianuta Dagalutian with regard	4 +0	DATE
		with NFPA 25, 2011 Edition,			Dispute Resolution with regard	ו נט	
		Inspection, Testing and			tags K 354 deficiency.	<b>.</b> .	
		ter-Based Fire Protection			The K 354 Sprinkler System -		
		, 15.5.2 requires nine			of Service, deficiency cited she	ould	
	_	impairment coordinator shall			be deleted. The deficiency		
		(b) states a fire watch should			stated:		
	•	ersonnel who continuously					
	patrol the affected a	area. Ready access to fire			The fire watch plan failed to		
	extinguishers and th	ne ability to promptly notify			include contacting the Indiana		
	the fire department	are important items to			State Department of Health via	a the	
	consider. During the	e patrol of the area, the person			ISDH Gateway link at		
	should not only be l	looking for fire, but making			https://gateway.isdh.in.gov as	the	
		ire protection features of the			primary method or by the		
		ress routes and alarm systems			secondary method when the IS	SDH	
		nctioning properly. This			Gateway is nonoperational by		
		ould affect all occupants in the			completing the Incident Repor	tina	
	facility.	said affect all occupants in the			form and e-mailing it to	ung	
	lacinty.				incidents@isdh.in.gov. Based	on	
	Findings include:						
	rindings include.				interview during the record rev	iew,	
	D 1 1				the Executive Director		
		view and interview with the			acknowledged the fire watch		
		and Maintenance Director from			documentation provided stated	o to	
	-	09/07/23 between 10:10 a.m.			contact the Indiana State		
	_	ire watch plan failed to include			Department of Health at a pho	ne	
		ina State Department of Health			number, and not via the ISDH		
	via the ISDH Gatev	-			Gateway link or at the e-mail		
		n.in.gov as the primary method			listed above.		
		method when the ISDH					
		rational by completing the			The surveyor erred in citating	the	
	Incident Reporting	form and e-mailing it to			facility at K 354 Sprinkler System	em	
	incidents@isdh.in.g	gov. Based on interview			- Out of Service because the t	here	
	during the record re	view, the Executive Director			is no CMS, NFPA or Indiana s	tate	
	acknowledged the f	ire watch documentation			mandate which requires skilled		
	_	ontact the Indiana State			nursing providers to specificall		
	-	th at a phone number, and not			use a specific 'portal' or email	,	
	_	vay link or at the e-mail address			address to notify the Indiana		
		ED stated that this was an issue			Department of Health. This 'p	ortal'	
		uring the survey no additional			or email would the Indiana	o, tai	
		itation was provided.			Department of Health's preferr	od.	
I	i me waten documen	nanon was provided.	i		i Department of Health's preferr	<del>c</del> u	I

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

Event ID:

ICQ521 Fac

Facility ID: 000316

method but is not the law.

If continuation sheet

Page 32 of 42

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

PRINTED: 11/08/2023 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		UILDING	03	COMPL	
		155491	B. W	ING		09/07/	2023
	PROVIDER OR SUPPLIER		<u>.</u>	1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN 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	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	The finding was rev	viewed with the Executive					
	Director at the time	of discovery and again at the			NFPA 25 Inspection, Testing	and	
	exit conference with	n the Executive Director, and			Maintenance of Water-Based	Fire	
	Maintenance Direct	or from another facility			Protection Systems manages the		
	present.				ITM provisions for water-base	d fire	
					protection systems with the		
	3.1-19(b)				ultimate goal of maintaining		
					system readiness at a high lev	el of	
					reliability. Providing a fire wate		
					often a preferred method vers		
					evacuation and when there is	an	
					outage requires the service		
					provider to make notification to	o an	
					acceptable authority having		
					jurisdiction (AHJ). Furthermor		
					the NFPA 101, Life Safety Co		
					state that one of the expected		
					notifications may be to a licens	-	
					authority having jurisdiction bu		
					does not require a specific mo	de	
					of the notification.		
					The facility as confirmed by the	ne	
					surveyor does include in the		
					notification section of the Fire		
					Alarm Outage – Fire Watch po	olicy	
					and procedure the phone num		
					to the Indiana Department of		
					Health which would be reason	able	
					to notify of an engaged fire wa	itch.	
					For the above stated reason, t	he	
					deficiency K 346 should be		
					deleted as the facility is clearly	/ in	
					compliance having met the de	-	
					of burden by including the con	tact	
					information of the Indiana		
					Department of Health in its Fir	е	
					Watch Policy.		
					Administrator/ Designee ensu	red	
					that a fire watch plan was		

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 33 of 42

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

11/08/2023 PRINTED: FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC		OMI	B NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 09/07/2023	
	PROVIDER OR SUPPLIER		1029 E	ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331	D	
(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 APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
				implemented that included the ISDH Gateway Link no late that 09/26/2023 Administrator/ Designee ensure that the fire watch plan with ISI Gateway link is implemented. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding regulation that requires the ISE Gateway Link to be listed as a primary or secondary method of communication.  Maintenance Director/ Designed will audit the fire watch plan monthly x3 to ensure that the fire watch plan includes the gateway link as a primary and secondary method of communication and then as determined by the QAA Committee.	ed DH g the DH of ee ire ay	
K 0355 SS=E Bldg. 03	installed, inspected accordance with Nortable Fire Extinutes 18.3.5.12, 19.3.5. Based on observation failed to maintain 1 in the kitchen cook	nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility of 1 portable fire extinguishers ing area in accordance with the	K 0355	Maintenance Director/ Designe will ensure that K class fire extinguishers have the proper		09/26/2023
	requirements of NF	PA 10. NFPA 10, Standard for guishers, 2010 Edition, Section		signage per code. This was d no later than 09/26/2023.	one	

5.5.5 states fire extinguishers provided for the

combustible cooking media (vegetable or animal

protection of cooking appliances using

Maintenance Director/ Designee

extinguishers have the proper

ensured that K class fire

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 03		COMPLETED		
		155491	B. W	ING		09/07/	/2023	
		l .		CTDEET A	ADDRESS CITY STATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP COD					
MA IEST		JEDSVII I E	1029 E 5TH STREET					
MAJESTIC CARE OF CONNERSVILLE				CONNERSVILLE, 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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	oils and fats) shall b	be listed and labeled for Class			signage. This was completed	by		
	K fires. NFPA 10,	5.5.5.3 states a placard shall be			09/26/2023			
	placed near the exti	nguisher that states that the			On 09/11/2023 the facility			
	protection system s	hall be actuated prior to using			administrator educated the			
	the fire extinguishe	r. Since the fixed fire			maintenance director regardin	g the		
	extinguishing syste	m will automatically shut off			regulation the requires K class	s fire		
	the fuel source to the	ne cooking appliance, the fixed			extinguishers to have a sign th	nat		
	system should be as	ctivated before using the			indicates the extinguisher is or	nly		
	portable fire exting	uisher. In this instance, the			to be used after the Ansel sys	tem		
	portable fire exting	uisher is supplemental			is activated.			
	protection. This deficient practice could affect				Maintenance Director/ Design	ee		
	five staff in the kitchen.				will audit K class fire extinguis	hers		
					for proper Weekly x 4, and the	n as		
	Findings include:				determined by the QAA			
					Committee.			
	Based on observation	ons and interviews during a						
	tour of the facility v	with the Executive Director and						
	Maintenance Direct	tor from another facility on						
	09/07/23 between 1	:20 p.m. and 4:50 p.m., a						
	portable K Class fir	e extinguisher was located in						
	the West Building l	kitchen and a placard was not						
		ed near the extinguisher which						
	1	ction system shall be activated						
		re extinguisher. The proper						
		t in the East Building kitchen						
	,	ise) but was missing in the						
	West Building Kitc	hen (which is in use).						
	_	knowledged by the Executive						
		enance Director from another						
	· ·	of discovery and again at the						
		h the Executive Director and						
	Maintenance Direct	tor from another facility						
	present.							
	3.1-19(b)							
14 0000								
K 0363	NFPA 101							
SS=E	Corridor - Doors							
Bldg. 03	Corridor - Doors							

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

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet Page 35 of 42

PRINTED: 11/08/2023

CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491			A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING 03 COMPLI  B. WING 09/07/2				
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE	
	Doors protecting of than required endexits, or hazardout of smoke and are solid-bonded core capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller In CMS regulation. The apply to auxiliary flammable or come Clearance between covering is not extended with a standard with a control of the door closed with a standard with a standard with the door closed with a standard with the close of standard with the standard with the close of standard with the standard	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material ing fire for at least 20 fully sprinklered smoke conly required to resist the conformal control of the corridor doors and doors in glammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 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 red protective plates of re permitted. Dutch doors 6 are permitted. Door beled and made of steel or compliance with 8.3,						

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

devices, etc.

Show in REMARKS details of doors such as fire protection ratings, automatics closing

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 36 of 42

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 03			COMPLETED		
		155491	B. WIN	B. WING			09/07/2023	
			Щ.					
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					5TH STREET			
MAJESTIC CARE OF CONNERSVILLE				CONNE	ERSVILLE, IN 47331			
(V4) ID	CHMMADV	CTATEMENT OF DEFICIENCIE		ID			(Y5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	'	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		on and interview, the facility	K 03	363	Maintenance Director/ Designe		09/26/2023	
		corridor doors had no			will ensure that doors that do r	not		
	impediment to closi	ing and latching into the door			latch into their frame will do so	by		
	frame and would re	sist the passage of smoke.			09/26/2023.			
	This deficient pract	ice could affect 6 staff and 20			Maintenance Director/ Designo	ee		
	residents.				ensured that doors latched			
					positively into their respective			
	Findings include:				frames. This was completed by	)V		
					09/26/2023			
	Based on observation	ons and interview during a			On 09/11/2023 the facility			
		with the Executive Director and			administrator educated the			
	-					41		
	Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., the				maintenance director regardin	-		
		• •			regulation that requires doors	Ю		
	_	doors in the West Building			latch positively into their			
	_	ively into their respective door			respective frames.			
	frames:				Maintenance Director/ Designo	ee		
		e Room - equipped with a			will audit doors weekly x 4 to			
	self-closing device.				ensure they latch positively int	0		
	b) The Kitchen Do	or near the soda machine -			their respective frames.			
	equipped with a sel	f-closing device.						
	c) The Dietary Dire	ectors Office						
	d) Resident Room	#807						
	e) Resident Room	#810						
	/	LD room on the 900 hall -						
	equipped with a sel							
		n nurses station on 600 Hall -						
	equipped with a self							
	equipped with a ser	r-closing device.						
	The finding was as!	anousladged by the Evecutive						
	The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the							
		h the Executive Director and						
		for from another facility						
	present.							
	3.1-19(b)							
K 0511	NFPA 101							
SS=F	I Itilities - Gas and	Flectric						

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

Utilities - Gas and Electric

Bldg. 03

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 37 of 42

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491  NAME OF PROVIDER OR SUPPLIER  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET	COMPLETED 09/07/2023
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET	09/07/2023
NAME OF PROVIDER OR SUPPLIER  1029 E 5TH STREET	
MAJESTIC CARE OF CONNERSVILLE 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)	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.  18.5.1.1, 19.5.1.1, 9.1.2  Based on observation and interview, the facility failed to ensure electrical outlets were protected in the dining area according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6. Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 15 residents, staff and visitors.  Findings include:  Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., in the dining hall near the kitchen door an outlet cover protecting the electrical outlet was not completely covering the receptacle and appeared to be broken with pieces missing.  The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility on the direct proposed to be broken with pieces missing.  The surveyor erred in citating facility at because the receptal plate had just been broken an there was a workorder to maintenance department to repl	O9/26/2023  O9/26/2023  Odd  dd  ctor  m  .m.,  nen  g the  stacle th  the ble

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155491	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 09/07/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET  CONNERSVILLE, IN 47331					
(X4) ID PREFIX	(EACH DEFICIEN	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 DEFICIENCY)				
TAG	REGULATORY OF	A LSC IDENTIFYING INFORMATION	TAG	submitted.  This is a single instance and the above stated reason above deficiency K 511 should be deleted as the facility was clear concerned and recognized the need to replace the receptable plate.  Maintenance Director/ Design ensured that outlet covers completely covered receptable This was completed by 09/26/2023  On 09/11/2023 the facility administrator educated the maintenance director regarding regulation that requires walls for remain free of holes that could allow the passage of smoke through the smoke barrier.  Maintenance Director/ Design will audit outlet covers to ensurthat they completely cover receptacles weekly x 4 and the as determined by QAA committee.	e the arly e e e e e e e i g the to d e e e i re			
K 0712 SS=F Bldg. 03	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. Ir with procedures and is						

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

aware that drills are part of established

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

Page 39 of 42

				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>03</u>			COMPLETED	
		155491	B. WING 09/07/2023					
	PROVIDER OR SUPPLIER		<u>,                                      </u>	STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINERIC DI AM 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)	VIE.	DATE	
IAU	routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record rev failed to conduct fir quarters. LSC 19.7 conducted quarterly facility personnel (r engineers, and adms signals and emerger varied conditions. all staff and residen  Findings include:  Based on record rev Executive Director another facility on ( and 1:20 p.m., the 1 fire drill documenta Executive Director stated that it appear was not completed of time.  The finding was rev Director at the time exit conference with	AM, a coded ay be used instead of 19.7.1.7  View and interview, the facility re drills on each shift for 1 of 4  1.1.6 states drills shall be reach on each shift to familiarize nurses, interns, maintenance inistrative staff) with the next action required under This deficient practice affects	K 0	712	Maintenance Director/ Design will ensure that fire drills are completed per regulation requirements no later than 09/26/2023 Maintenance director/ Design ensured that fire drills are completed per regulation. Thi was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regardin regulation that requires one fill drill per shift per quarter. Maintenance Director/ Design will audit weekly x 4 and then determined by the QAA Committee to ensure that fire are done as the regulation requires.	ee is is ing the re ee as	09/26/2023	
K 0920	NFPA 101							
SS=E		ent - Power Cords and						
Bldg. 03	Extens							
	Electrical Equipme	ent - Power Cords and						

PRINTED: 11/08/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>03</u>			COMPLETED		
		155491	B. W	NG		09/07	09/07/2023		
				STREET	ADDRESS CITY STATE ZIP COD	<u> </u>			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD  1029 E 5TH STREET					
MAJESTIC CARE OF CONNERSVILLE					ERSVILLE, IN 47331				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
1110	Extension Cords			1110			BIIIE		
		patient care vicinity are only							
	used for compone	•							
		ed electrical equipment							
	-	ples that have been							
	'	alified personnel and meet							
		10.2.3.6. Power strips in							
		icinity may not be used for							
	•	, personal electronics),							
	` •	m care resident rooms that							
		E. Power strips for PCREE							
		or UL 60601-1. Power strips							
	for non-PCREE in the patient care rooms								
		y) meet UL 1363. In							
		rooms, power strips meet							
	-	ds. All power strips are							
		I precautions. Extension							
	_	d as a substitute for fixed							
		ire. Extension cords used							
		emoved immediately upon							
		purpose for which it was							
		ets the conditions of 10.2.4.							
		9), 10.2.4 (NFPA 99), 400-8							
	,	(D) (NFPA 70), TIA 12-5							
		on and interview, the facility	K 0	920	Maintenance Director/ Design	ee	09/26/2023		
		of 1 power strips were not used	" "		will ensure that high draw		33.20.2025		
		ixed wiring to provide power			equipment is plugged into				
	equipment with a h	nigh current draw.			electrical receptacles not pow	er			
		0.8 state unless specifically			strips. This will be done no la				
		flexible cords and cables shall			than 09/26/2023				
	_	as a substitute for fixed wiring.			Maintenance Director/ Design	ee			
		tice could affect up to 2 staff in			ensured that high draw equipr				
	the ISPD office.	-			is plugged into electrical				
					receptacles instead of power				
	Findings include:				strips. This was done by				
					09/26/2023				
	Based on observati	ons and interviews during a			On 09/11/2023 the facility				
		with the Executive Director and			administrator educated the				

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

Maintenance Director from another facility on

09/07/23 between 1:20 p.m. and 4:50 p.m. in room

Event ID:

ICQ521

Facility ID: 000316

If continuation sheet

maintenance director regarding the

regulation that requires high draw

Page 41 of 42

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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       03       COMPLETED         B. WING       09/07/2023					
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	(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)	TE	(X5) COMPLETION DATE
	strip was being used refrigerator (high portion of the finding was acknowledged). The finding was acknowledged and Mainte facility at the time of exit conference with	D as the "ISPD Office" a power of to power a dorm style ower draw equipment).  It considers the end of the end			equipment to be plugged into electrical receptacles instead of power strips.  Maintenance Director/ Designor will audit weekly x 4 to ensure high draw equipment is plugged directly into electrical receptacles.	ee	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ICQ521 Facility ID: 000316 If continuation sheet Page 42 of 42