DEPART		FORM APPROVED						
		MEDICAID SERVICES					D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDII	NG _		R-C		
		155491	B. WING			10/05/2023		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
				1	029 E 5TH STREET			
MAJESTIC	MAJESTIC CARE OF CONNERSVILLE				ONNERSVILLE, IN 47331			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION	
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG					
					DEFICIENCY)			
			[
{F 000}	0} INITIAL COMMENTS		{F 0	00}				
	This visit was for a Post Survey Revisit (PSR) to							
	the Investigation of Complaint IN00415628 completed on August 24, 2023.							
	This visit was done in Conjunction with the PSR to the Recertification and State Licensure Survey and the PSR to Complaint IN00407259 and							
	IN00414446 completed on August 24, 2023.							
	Complaint IN00415628 - Corrected.							
	Complaint IN00407259 - Corrected.							
	Complaint IN00414446 - Corrected. Survey date: October 5, 2023							
	Facility number: 000316							
	Provider number: 155491							
	AIM number: 100286370							
	Census Bed Type:							
	SNF/NF: 93							
	Total: 93							
	Census Pavor Type							
	Census Payor Type: Medicare: 7							
	Medicaid: 78							
	Other: 8							
	Total: 93							
	Majestic Care of Con	nersville was found to be in						
	compliance with 42 C	FR Part 483 Subpart B and						
	410 IAC 16.2-3.1 in regard to the PSR to the							
	Investigation of Comp	plaint IN00415628.						
	Quality review comple	eted on August 11, 2023						
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/12/2023

		FORM APPROVED						
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED R-C 10/05/2023		
		155491	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		J/05/2025		
MAJESTIC CARE OF CONNERSVILLE				1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)				

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

Event ID: NF4J12

Facility ID: 000316

If continuation sheet Page 2 of 2

PRINTED: 10/12/2023