	R MEDICARE & MEDIC						IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ´		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	<u></u>	COMPLETED	
		155491	B. WI	NG		03/16	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	3	
NAME OF	PROVIDER OR SUPPLIEF	R		1029 E	5TH STREET		
MAJEST	IC CARE OF CON	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE OPRIATE	COMPLETIO
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
ычу	An Emergency Pres	paredness Survey was	E 00	000			
		ndiana Department of Health	EU	000			
	in accordance with	-					
	in accordance with	42 CFR 483.75.					
	Survey Date: 03/10	6/21					
	Facility Number: 0	000316					
	Provider Number:						
	AIM Number: 100						
		200370					
	At this Emergency	Preparedness survey,					
		onnersville was found not in					
		mergency Preparedness					
	-	Aedicare and Medicaid					
	-	ders and Suppliers, 42 CFR					
	483.73						
		6 certified beds. At the time					
	of the survey, the c	ensus was 70.					
	Quality Review cor	mpleted on 03/23/21					
E 0004	403.748(a), 416.5	54(a), 418,113(a)					
SS=C	441.184(a), 482.1						
Bldg	483.73(a), 484.10	., .,					
Diag.	485.68(a), 485.72						
	486.360(a), 491.1	., .,					
		Review and Update					
	Annually						
		comply with all applicable					
		d local emergency					
		uirements. The [facility]					
		ablish and maintain a					
	1 '	mergency preparedness					
		ets the requirements of this					
	section.						
	000000				1		1

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

TITLE

(X6) DATE

PRINTED: 04/12/2021

FORM APPROVED

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COI		COM 03/*	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF		10	REET ADDRESS, CITY, STATE, ZIP ( 29 E 5TH STREET ONNERSVILLE, IN 47331	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC DATE	
	include, but not be elements: (a) Emergency Pla develop and main preparedness plan and updated at lea must do all of the * [For hospitals at §485.625(a):] Eme or CAH] must com Federal, State, an preparedness req CAH] must develo comprehensive er program that mee section, utilizing a * [For LTC Facilitie Emergency Plan. develop and main preparedness plan updated at least a * [For ESRD Facil Emergency Plan. develop and main preparedness plan and updated at least and updated at least and updated at least and updated at least	§482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or ap and maintain a mergency preparedness ts the requirements of this n all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed and nnually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated],	E 0004	1. the allegation is tha failed to develop and n emergency prepared was not reviewed and annually.	maintain an ness plan. It	04/19/20	
	affect all occupants Findings include:			<ol> <li>No residents were a all residents had poten risk by the deficient pr</li> <li>The Administrator</li> </ol>	ntial to be at actice.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MUL A. BUIL B. WINC	DING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
MAJEST (X4) ID PREFIX TAG 0006 SS=F Bldg	SUMMARY S (EACH DEFICIEN REGULATORY OF Based on review of Preparedness Plan documentation with the Maintenance D from 2:30 p.m. to 3 documentation for program reviewed 1 recent twelve mont review. The aforen dated as reviewed 1 month period. Bas record review, the L emergency program dated as reviewed 1 month period. Bas record review, the L emergency program dated as reviewed 10 month period. Bas record review, the L emergency program dated as reviewed 10 month period. This finding was re Director and the M the exit conference 403.748(a)(1)-(2), 418.113(a)(1)-(2), 485.625(a)(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 486.360(a)(1)-(2) Plan Based on Al [(a) Emergency P develop and mair preparedness pla and updated at le must do the follow	TATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION) The facility's "Emergency (Disaster Plan) In the Executive Director and irector during record review :45 p.m. on 03/16/21, a complete emergency by the facility within the most h period was not available for mentioned plans were not within the most recent twelve ed on interview at the time of Executive Director agreed the in documentation was not within the most recent twelve existent within the Executive aintenance Director during	PF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) updated and reviewed to El binder. 4. To ensure compliance th Maintenance Director or Designee will be responsible complete the QA monitoring weekly for 4 weeks and the monthly for 6 months. Res the audit will be presented to QA committee.	P P le to g tool n ults of	(X5) COMPLETIC DATE

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	î î	UILDING /ING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			STREET A	DE		
MAJES		IERSVILLE		CONNE	RSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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) COMPLETIC DATE
		ies for addressing s identified by the risk					
	Emergency Plan. develop and main preparedness plan and updated at lea do the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strateg	s at §483.73(a)(1):] The LTC facility must tain an emergency In that must be reviewed, ast annually. The plan must Ind include a documented, community-based risk ing an all-hazards ing missing residents. gies for addressing is identified by the risk					
	and maintain an e plan that must be least every 2 year following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strateg	The ICF/IID must develop mergency preparedness reviewed, and updated at s. The plan must do the nd include a documented, community-based risk ing an all-hazards					
	and maintain an e plan that must be least every 2 year following: (1) Be based on a	§418.113(a)(2):] The Hospice must develop mergency preparedness reviewed, and updated at s. The plan must do the nd include a documented, community-based risk					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. Based on record review and interview, the E 0006 1. The allegation is that the facility 04/19/2021 failed to maintain a risk facility failed to maintain an emergency preparedness plan that was (1) based on and assessment and was not available for review. includes a documented, facility-based and community-based risk assessment, utilizing an 2. No residents were effected, but all residents had the potential to all-hazards approach, including missing residents and (2) included strategies for addressing be at risk by this deficient emergency events identified by the risk practice. assessment in accordance with 42 CFR 3. The Administrator has updated 483.73(a) (1) and 42 CFR 483.73(a) (2). In the an updated Risk Assessment Survey & Certification memo QSO: 19-06-ALL utilizing an all hazards approach. dated 02/01/19, the Centers for Medicare and 4. To ensure compliance the Medicaid Services (CMS) updated Appendix Z of Administrator or Designee will be the State Operations Manual to reflect changes responsible to complete the QA monitoring tool weekly for 4 to add emerging infectious diseases to the definition of all-hazards approach and stated weeks, then monthly x 6 months. Results of audit findings will be "Planning for using an all-hazards approach should also include emerging infectious disease presented to QA committee. (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, was not available for review. Based on

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

Event ID:

VZOT21 Facility ID:

Facility ID: 000316

If continuation sheet

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PRINTED:

04/12/2021

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155491	A. BUILDING B. WING	CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE		1029	T ADDRESS, CITY, STATE, ZIF E 5TH STREET NERSVILLE, IN 47331	P CODE		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
0007 SS=C Bldg	Executive Director facility-based and of assessment, utilizin specific to Majestic not available for rea This finding was ree Director and the M the exit conference 403.748(a)(3), 41 441.184(a)(3), 48 483.73(a)(3), 484 485.68(a)(3), 485 491.12(a)(3), 494 EP Program Patie [(a) Emergency P develop and main preparedness pla and updated at le must do the follow (3) Address [patie including, but not the type of service ability to provide i continuity of opera delegations of aut plans.** *[For LTC facilities Emergency Plan. develop and main preparedness pla and updated at le (3) Address reside but not limited to, services the LTC	6.54(a)(3), 418.113(a)(3), 2.15(a)(3), 483.475(a)(3), .102(a)(3), 485.625(a)(3), .727(a)(3), 485.920(a)(3), .62(a)(3) ent Population lan. The [facility] must tain an emergency in that must be reviewed, ast every 2 years. The plan <i>v</i> ing:] ent/client] population, limited to, persons at-risk; es the [facility] has the in an emergency; and ations, including thority and succession is at §483.73(a)(3):] The LTC facility must tain an emergency in that must be reviewed,					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	r í	ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COE 1029 E 5TH STREET			
INAJES I	IC CARE OF CON	NERSVILLE		CONN	ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	operations, includ and succession pl	ing delegations of authority ans.					
		at risk" does not apply to: CE, HHA, CORF, CMCH, SRD facilities.]					
	facility failed to ensight preparedness plan a including, but not li- type of services the to provide in an em- operations, includir and succession plar 483.73(a)(3). This of affect all occupants Findings include:	ddressed resident population, mited to, persons at-risk; the LTC facility has the ability ergency; and continuity of g delegations of authority is in accordance with 42 CFR deficient practice could	E 00	007	<ol> <li>The allegations is that the facility did not maintain a faci based and community based assessment, utilizing an all hazards approach, specific to Majestic Care of Connersville</li> <li>No residents were affected but all residents had potentia be at risk by this deficient practice.</li> <li>The Administrator immedia placed an updated communit based risk assessment and utilizing an all hazards approximation</li> </ol>	risk d, to tely	04/19/202
	the Maintenance Di from 2:30 p.m. to 3 documentation coul emergency prepared resident population	a the Executive Director and rector during record review :45 p.m. on 03/16/21, no d be found ensuring the dness plan addressed the , including, but not limited to,			specific to Majestic Care of Connersville in the EP manua 4. To ensure compliance the Administrator or Designee wi responsible to complete the C tool Weekly for 4 weeks and monthly x 6 months. Results	l be QA then of	
	facility has the abili emergency; and con including delegation plans. Based on intr review, the Executi unable to provide p services the LTC fa provide in an emerge	ntinuity of operations, ns of authority and succession erview at the time of record ve Director agreed she was olicies regarding the type of cility has the ability to gency; and continuity of g delegations of authority			audit findings will be presente the QA committee.	a to	
	This finding was re	viewed with the Executive					

ENTERS FO	T OF HEALTH AND HU R MEDICARE & MEDIC	AID SERVICES					FORM APPROVEI DMB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. I	MULTIPLE CO BUILDING WING	INSTRUCTION	(X3) DA COM	TE SURVEY IPLETED 16/2021
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP	CODE	
MAJEST	IC CARE OF CONN	IERSVILLE			5TH STREET RSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIO
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Director and the Ma	aintenance Director during					
	the exit conference.						
: 0015 SS=C Bldg	<ul> <li>(1), 482.15(b)(1), 4</li> <li>(1), 485.625(b)(1)</li> <li>Subsistence Need</li> <li>[(b) Policies and p</li> <li>must develop and</li> <li>preparedness polition</li> <li>based on the emety</li> <li>paragraph (a) of the section, and the comparagraph (c) of the and procedures mupdated every 2 y</li> <li>At a minimum, the must address the</li> <li>(1) The provision of staff and patients</li> <li>shelter in place, in the following:</li> </ul>	Is for Staff and Patients rocedures. [Facilities] implement emergency cies and procedures, rrgency plan set forth in his section, risk ragraph (a)(1) of this ommunication plan at his section. The policies nust be reviewed and ears (annually for LTC). policies and procedures following: of subsistence needs for whether they evacuate or icclude, but are not limited to er, medical and					
	(ii) Alternate s maintain the follow	sources of energy to ving:					
	health and safety sanitary storage o (B) Emer (C) Fire o and alarm system	gency lighting. detection, extinguishing,					
	*[For Inpatient Ho (iii):] Policies and (6) The following a	spice at §418.113(b)(6)					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMP	LETED
		155491	B. WI	NG		03/16/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ËR			5TH STREET		
MAJEST	TIC CARE OF CON	NERSVILLE			ERSVILLE, IN 47331		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s and procedures must					
	address the follow	-					
		ision of subsistence needs					
		oyees and patients, whether					
	-	shelter in place, include,					
		d to the following:					
	(A) Food, water, medical, and						
	pharmaceutical s						
	(B) Alter						
	maintain the follo	-					
		Temperatures to protect					
		patient health and safety and for the safe and sanitary storage of provisions.					
		Emergency lighting.					
		Fire detection, extinguishing,					
	and alarm system	ns. /age and waste disposal.					
	Based on record re		215	1. The allegations is that the		04/10/202	
		E 00	515	facility did not have the EP		04/19/202	
		facility failed to ensure emergency preparedness policies and procedures include at a minimum,			documentation in place to inc	abul	
		of subsistence needs for staff			subsistence needs for food, v		
		ther they evacuate or shelter in			or pharmaceutical review.	valor	
		are not limited to the			2. No residents were affecte	Ч	
	-	d, water, medical, and			but all residents in those area	-	
		pplies. (ii) Alternate sources			had the potential to be at risk		
		ain - (A) Temperatures to			this deficient practice.		
		alth and safety and for the safe			3. The Administrator immedi	ately	
	-	ge of provisions; (B)			placed all information needed	-	
		g; (C) Fire detection,			subsistence need for food, w		
		alarm systems; and (D)			and pharmaceutical review in		
		disposal in accordance with 42			EP binder.		
	CFR 483.73(b)(1).	This deficient practice could			4. To ensure compliance the		
	affect all occupant	s.			Administrator or Designee wi		
					responsible to complete the (	QA	
	Findings include:				monitoring tool weekly for 4 weeks, then monthly x 6 mor	ths	
	Based on review of the	f the facility's "Emergency			Results of audit findings will t		
	Preparedness Plan	(Disaster Plan)			presented to the QA committe	ee.	
	documentation wit	th the Executive Director and					
	the Maintenance D	Director during record review					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MUL A. BUIL B. WING	DING	ISTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			1029 E 5	DRESS, CITY, STATE, ZIP CODE TH STREET RSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETIC DATE
0018 SS=C Bldg	subsistence needs d emergency prepared incomplete. The dd subsistence needs f pharmaceutical sup extremes. Based on record review, the I emergency prepared did not include all s This finding was re Director and the Ma the exit conference. 403.748(b)(2), 414 (ii) and (v), 441.18 483.475(b)(2), 48 485.920(b)(1), 48 Procedures for Tr Patients [(b) Policies and p must develop and preparedness pol based on the eme paragraph (a) of t assessment at pa section, and the c paragraph (c) of tt and procedures m updated at least e LTC).] At a minim procedures must [(2) or (1)] A syste on-duty staff and a [facility's] care dur on-duty staff and a	becomentation did not include or food, water, plies and temperature in interview at the time of Executive Director agreed dness program documentation subsistence needs. viewed with the Executive aintenance Director during (5.54(b)(1), 418.113(b)(6) (34(b)(2), 482.15(b)(2), (3.73(b)(2), 485.625(b)(2), (3.60(b)(1), 494.62(b)(1)) acking of Staff and procedures. The [facilities] implement emergency cies and procedures, argency plan set forth in					

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155491	A. E	UILDING /ING	NSTRUCTION	COM 03/	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP 5TH STREET ERSVILLE, IN 47331	CODE		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	·····		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	RRECTION SHOULD BE	COMPLETIC	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
	location of the rec location.	eiving facility or other						
	§483.73(b), ICF/II at §460.84(b):] Po	l41.184(b), LTC at Ds at §483.475(b), PACE licies and procedures. (2) the location of on-duty staff						
	and sheltered res ICF/IID or PACE] emergency. If on	idents in the [PRTF's, LTC, care during and after an -duty staff and sheltered						
	PACE] must docu	PRTF's, LTC, ICF/IID or ment the specific name						
	location.	e receiving facility or other						
	Policies and proc	spice at §418.113(b)(6):] edures. on from the hospice, which						
	includes consider needs of evacuee	ation of care and treatment s; staff responsibilities;						
	location(s) and pr	ntification of evacuation imary and alternate means with external sources of						
		ack the location of hospice ty and sheltered patients in						
	the hospice's care the on-duty emplo	e during an emergency. If oyees or sheltered patients ng the emergency, the						
	hospice must doc	ument the specific name e receiving facility or other						
	procedures. (2) S	485.920(b):] Policies and afe evacuation from the udes consideration of care						
	and treatment nee responsibilities; tr	addes of evacuees; staff ansportation; identification ation(s); and primary and						

PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) alternate means of communication with external sources of assistance. \*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. \*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the E 0018 1. The allegation is that the 04/19/2021 facility failed to ensure emergency preparedness facility had no policy or procedure to track staff and resident during policies and procedures include a system to track an emergency. the location of on-duty staff and sheltered 2. No residents were affected, residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered but all residents had the potential residents are relocated during the emergency, the to be at risk by this deficient practice. LTC facility must document the specific name and location of the receiving facility or other 3. The Administrator immediately location in accordance with 42 CFR 483.73(b) placed the policy and procedure (2). This deficient practice could affect all to track staff and residents during an emergency into the EP binder. occupants, 4. Findings include: To ensure compliance the Administrator or Designee will be Based on review of the facility's "Emergency responsible to complete the QA Preparedness Plan (Disaster Plan) monitoring tool weekly for 4 weeks documentation with the Executive Director and and monthly x 6 months. the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, VZOT21 Facility ID: 000316

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

Event ID:

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE. IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG the Executive Director confirmed no policies and procedure for tracking staff and residents was available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. E 0020 403.748(b)(3), 416.54(b)(2), 418.113(b)(6) SS=C (ii), 441.184(b)(3), 482.15(b)(3), 483.475(b) Bldg. --(3), 483.73(b)(3), 485.625(b)(3), 485.68(b) (1), 485.727(b)(1), 485.920(b)(2), 491.12(b) (1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. \*[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 13 of 81

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/16/2021		
	PROVIDER OR SUPPLIE			1029 E	T ADDRESS, CITY, STATE, ZIP CODE E 5TH STREET			
MAJESI	IC CARE OF CON	NERSVILLE		CONN	ERSVILLE, IN 47331			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES 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 APPROPRIDEFICIENCY)		(X5) COMPLETIC DATE	
	<ul> <li>(iii) Transportatio</li> <li>(iv) Identification</li> <li>(v) Primary and a communication wassistance.</li> <li>* [For CORFs at Rehabilitation Ag §485.727(b)(1), a §494.62(b)(2):]</li> <li>Safe evacuation Rehabilitation Ag Agencies as Provide Therapy and Species as Provide Therapy and Species as Provide Services; and ES includes staff rest the patients.</li> <li>* [For RHCs/FQF evacuation from fincludes appropristaff responsibilitit patients.</li> <li>Based on record refacility failed to er policies and proces affe evacuation from fincludes consideraneeds of evacues; transportation; ide location(s); and pricommunication wiassistance in accord (3). This deficient occupants.</li> <li>Findings include:</li> </ul>	n. of evacuation location(s). Ilternate means of <i>v</i> ith external sources of §485.68(b)(1), Clinics, encies, OPT/Speech at and ESRD Facilities at from the [CORF; Clinics, encies, and Public Health <i>v</i> iders of Outpatient Physical eech-Language Pathology SRD Facilities], which ponsibilities, and needs of ACS at §491.12(b)(1):] Safe the RHC/FQHC, which fate placement of exit signs; ies and needs of the eview and interview, the asure emergency preparedness dures include information for om the LTC facility, which tion of care and treatment staff responsibilities; ntification of evacuation imary and alternate means of th external sources of dance with 42 CFR 483.73(b) practice could affect all	Е 0		<ol> <li>The allegation is that the facility had no documentation showed alternate means of communication.</li> <li>No residents were affecte but all residents had the pote to be at risk by this deficient practice.</li> <li>The Administrator added alternate means of communic the ED manual.</li> <li>To ensure compliance the Administrator or Designee wi responsible to complete the 0 monitoring tool weekly for 4 weeks, then monthly x 6 mor Results of audit finding will bo</li> </ol>	d, ntial cation ll be QA nths.	04/19/20	

PARTMENT OF HEALTH AND HU NTERS FOR MEDICARE & MEDIO						FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	` ´	ILDING	NSTRUCTION	CO	te survey Mpleted 16/2021
NAME OF PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COI	DE	
MAJESTIC CARE OF CON	NERSVILLE			5TH STREET RSVILLE, IN 47331		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY 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 APP DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
documentation with the Maintenance E from 2:30 p.m. to facility's Emergend documentation did alternate means of sources of assistan Based on interview the Executive Dire alternate means of documented. This finding was r Director and the M the exit conference 0022 403.748(b)(4), 44 SS=C (i), 441.184(b)(4) (2), 485.727(b)(2) (2), 494.62(b)(3) Policies/Procedu (b) Policies and p must develop and preparedness po based on the em paragraph (a) of assessment at pa section, and the e paragraph (c) of and procedures r updated at least LTC).] At a minin procedures must [(4) or (2),(3),(5), place for patients remain in the [fac	h the Executive Director and birector during record review 3:45 p.m. on 03/16/21, the cy Preparedness Program not include primary and communication with external ce during an emergency. v at the time of record review, actor agreed primary and communication was not eviewed with the Executive laintenance Director during c. 16.54(b)(3), 418.113(b)(6) , 482.15(b)(4), 483.475(b) 485.625(b)(4), 485.68(b) ), 485.920(b)(3), 491.12(b) res for Sheltering in Place procedures. The [facilities] d implement emergency licies and procedures, ergency plan set forth in this section, risk aragraph (a)(1) of this communication plan at this section. The policies nust be reviewed and every 2 years (annually for num, the policies and address the following:] (6)] A means to shelter in c, staff, and volunteers who			presented to the QA com	nmittee.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155491	A. BU B. WI	JILDING ING	G 0		eted 2021
	PROVIDER OR SUPPLIEI			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
E 0026 SS=C Bldg	for hospice-opera only. The policies address the follow (i) A means to she hospice employed hospice. Based on record re- facility failed to en policies and proced shelter in place for volunteers who ren accordance with 42 deficient practice c Findings include: Based on review of Preparedness Plan documentation with the Maintenance D from 2:30 p.m. to 3 documentation of e policies and proced during an emergend review. Based on i review, the Executi emergency prepare not include docume preparedness polici sheltering in place. This finding was re Director and the M the exit conference 403.748(b)(8), 41 (C)(iv), 441.184(b	are additional requirements ted inpatient care facilities and procedures must ving: elter in place for patients, es who remain in the view and interview, the sure emergency preparedness hures include a means to residents, staff, and nain in the LTC facility in 2 CFR 483.73(b)(4). This ould affect all occupants. E the facility's "Emergency (Disaster Plan) in the Executive Director and irector during record review 6:45 p.m. on 03/16/21, emergency preparedness hures for sheltering in place cy was not available for interview at the time of record ive Director agreed the dness plan for the facility did entation of emergency tes and procedures for eviewed with the Executive aintenance Director during	EO	022	<ol> <li>The allegation is that the facility did not include documentation of emergency preparedness policies and procedures for sheltering in pla in the EP binder.</li> <li>No resident was affected bu all residents had the potential t be at risk by this deficient practice.</li> <li>The Administrator immediat added the policy and procedur for sheltering in place in the EF binder.</li> <li>To ensure compliance the Administrator or Designee will responsible to complete the Q/ monitoring tool weekly for 4 weeks, the monthly x 6 months Results of audit findings will be presented to the QA committee</li> </ol>	ut co tely e o be A S.	04/19/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BUILDI B. WING	D MULTIPLE CONSTRUCTION BUILDING . WING STREET ADDRESS, CITY, STATE, ZIP CODE		(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEI		10	REET ADDRESS, CITY, STATE, ZIP ( 29 E 5TH STREET ONNERSVILLE, IN 47331	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES     ID       ACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       GULATORY OR LSC IDENTIFYING INFORMATION)     TAG		FIX PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETIO DATE	
	must develop and preparedness pol based on the eme paragraph (a) of t assessment at pa section, and the c paragraph (c) of t and procedures m updated at least e LTC).] At a minim procedures must (8) [(6), (6)(C)(iv), [facility] under a w Secretary, in acco of the Act, in the p treatment at an al by emergency ma *[For RNHCIs at § procedures. (8) T a waiver declared accordance with s provision of care a identified by emer officials. Based on record re- facility failed to em- policies and proced facility under a wai in accordance with the provision of care site identified officials in accorda	aiver Declared by procedures. The [facilities] implement emergency icies and procedures, ergency plan set forth in	E 0026	<ol> <li>The allegation is the facility did not express role of the facility under declared by the Secre</li> <li>No other residents affected, but all reside potential to be at risk to deficient practice.</li> <li>The Administrator in added the role of the facility and the secre</li> </ol>	ly state the er a waiver tary. were nts had the by the mmediately	04/19/20	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	r í	ILDING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/16/2021	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP C 5TH STREET	CODE		
MAJEST	IC CARE OF CON	NERSVILLE			ERSVILLE, IN 47331			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE / DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
E 0032 SS=C Bldg	Findings include: Based on review of Preparedness Plan documentation wit the Maintenance I from 2:30 p.m. to emergency prepare not expressly state waiver declared by with section 1135 interview at the tin Executive Directo preparedness plan expressly state the waiver declared by This finding was r Director and the M the exit conference 403.748(c)(3), 42 441.184(c)(3), 42 485.68(c)(3), 485 486.360(c)(3), 485 486.360(c)(3), 485 486.360(c)(3), 485 486.360(c)(3), 485 Primary/Alternate [(c) The [facility] an emergency pr plan that complie local laws and m at least every 2 y The communicat the following: (3) Primary and a communicating v (i) [Facility] s	f the facility's "Emergency (Disaster Plan) th the Executive Director and Director during record review 3:45 p.m. on 03/16/21, the edness plan for the facility did the role of the facility under a y the Secretary, in accordance of the Act. Based on ne of record review, the r agreed the emergency for the facility did not role of the facility under a y the Secretary. eviewed with the Executive faintenance Director during e. 16.54(c)(3), 418.113(c)(3), 32.15(c)(3), 483.475(c)(3), 4.102(c)(3), 485.625(c)(3), 5.727(c)(3), 485.920(c)(3), 01.12(c)(3), 494.62(c)(3) e Means for Communication must develop and maintain reparedness communication es with Federal, State and ust be reviewed and updated years (annually for LTC).] ion plan must include all of			a waiver declared by th Secretary to the EP bin 4. To ensure compliar Administrator or Desig responsible to complet monitoring tool weekly weeks, then monthly x Results of audit finding presented to the QA co	ne nder. nce the nee will be te the QA for 4 6 months. gs will be		

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

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMPLE	TED
		155491	B. WI	NG		03/16/2	2021
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	ξ			5TH STREET		
MAJEST	IC CARE OF CON	NERSVILLE			ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	3	COMPLETIC
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
		management agencies.					
	*/Ear ICE//IDa at 8	\$492.475(a):1(2) Drimon(					
		§483.475(c):] (3) Primary ans for communicating with					
		, Federal, State, tribal,					
		al emergency management					
	agencies.						
	-	view and interview, the	E 00	032	1. The allegation is that the		04/19/202
		sure the emergency			facility did not have available	e the	5 11 1 71 201
	-	nunication plan includes (3)			policies and procedures incl		
		ate means for communicating			the primary and alternate me	eans	
	with the following:	(i) LTC facility's staff (ii)			for communication with staff		
	Federal, State, triba				federal, state, tribal regional		
		ement agencies in accordance			local emergency manageme	nt	
		3(c)(3). This deficient			agencies in the EP manual.		
	practice could affect	et all occupants.			2. No residents were affected		
					residents had the potential to		
	Findings include:				risk by this deficient practice		
					3. The Administrator immed added the alternate means of	-	
	Based on review of	f the facility's "Emergency			communication with staff, fe		
	Preparedness Plan				state, tribal, regional or local		
		h the Executive Director and			emergency management		
		irector during record review			agencies into the WP manua	al.	
		3:45 p.m. on 03/16/21, the			4. To ensure compliance the		
	Emergency Prepare				Administrator or Designe wil		
	documentation did	not include primary and			responsible to complete the	QA	
		communicating with staff,			monitoring tool weekly for 4		
		al, regional, or local			weeks, then Monthly x6. Re		
		ement agencies. Based on			of audit findings will be prese	ented	
		ne of record review, the			to the QA committee.		
		agreed all policies and					
	-	ng the primary and alternate					
		icating with staff, Federal,					
		al, or local emergency					
	review.	ies was not available for					
	I his finding was re	eviewed with the Executive			1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	ULTIPLE CO JILDING	(X3) DATE SURVEY COMPLETED				
		155491	B. WING				03/16/2021		
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE				
MAJEST	TIC CARE OF CON	NERSVILLE			5TH STREET RSVILLE, IN 47331				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	Director and the M the exit conference	laintenance Director during							
0036	403.748(d), 416.	54(d), 418.113(d),							
SS=C		15(d), 483.475(d),							
Bldg		D2(d), 485.625(d),							
U		27(d), 485.920(d),							
	486.360(d), 491.	., .,							
	EP Training and	Testing							
		§403.748, ASCs at							
	§416.54, Hospice	e at §418.113, PRTFs at							
	•	at §460.84, Hospitals at							
	-	t §484.102, CORFs at							
	-	t §486.625, "Organizations"							
		MHCs at §485.920, OPOs							
	-	C/FHQs at §491.12:]							
		esting. The [facility] must							
		ntain an emergency							
		ining and testing program							
		the emergency plan set forth							
		of this section, risk aragraph (a)(1) of this							
		and procedures at							
		this section, and the							
		lan at paragraph (c) of this							
		ning and testing program							
		and updated at least every							
	2 years.								
		3.73(d):] (d) Training and							
	-	facility must develop and							
		rgency preparedness							
	-	ng program that is based on							
	• • •	lan set forth in paragraph							
		, risk assessment at							
		of this section, policies and							
		ragraph (b) of this section,							
		ication plan at paragraph (c)							
		he training and testing							
	program must be	reviewed and updated at					1		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2021
	PROVIDER OR SUPPLIEI		1029	T ADDRESS, CITY, STATE, ZIP CODE E 5TH STREET NERSVILLE, IN 47331	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	e comple
	testing. The ICF/I maintain an emer training and testin the emergency pli (a) of this section, paragraph (a)(1) of procedures at par and the communi- of this section. The program must be least every 2 year the requirements training at §483.4 *[For ESRD Facility Training, testing, a dialysis facility mu- emergency prepara and patient orient on the emergency (a) of this section, paragraph (a)(1) of procedures at par and the communi- of this section. The orientation program updated at every Based on record rea- facility failed to define emergency prepare program that was re-	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based or plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and 2 years. view and interview, the velop and maintain an dness training and testing eviewed and updated at least nce with 42 CFR 483.73(d).	E 0036	<ol> <li>The allegation is that the facility documentation did no include a statement that stat training on emergency preparedness policies and procedures would be condu- and documented, on an ann bases.</li> <li>No residents were affected but residents had the potent</li> </ol>	ot ff cted ual ed,

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	r í	VILDING	ONSTRUCTION	(X3) DATE COMPI 03/16	LETED
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
MAJEST	IC CARE OF CON	INERSVILLE			E 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
E 0037 SS=F Bldg	Based on review of Preparedness Plan documentation wit the Maintenance I from 2:30 p.m. to facility's emergend testing program do The documentation that staff training of policies and proce documented, at a fill Based on interview and at the exit interview and the exit conference 403.748(d)(1), 44 483.73(d)(1), 48 486.360(d)(1), 48 486.360(d)(1), 48 486.360, RHC/I Training program the following: (i) Initial train preparedness por new and existing	of the facility's "Emergency (Disaster Plan) th the Executive Director and Director during record review 3:45 p.m. on 03/16/21, the cy preparedness training and bocumentation was incomplete. In failed to include a statement on emergency preparedness dures would be conducted and minimum, on an annual basis. w at the time of record review erview at 3:00 p.m., the r agreed the documentation did ment that staff training on edness policies and procedures ed and documented, at a nnual basis. reviewed with the Executive Maintenance Director during e. 16.54(d)(1), 418.113(d)(1), 82.15(d)(1), 485.920(d)(1), 5.727(d)(1), 485.920(d)(1), 91.12(d)(1) gram §403.748, ASCs at als at §482.15, ICF/IIDs at			be at risk by this deficient practice. 3. The Administrator immedia placed statement that staff tra on emergency preparedness policies and procedures would conducted and documented of annual basis in the ED binder 4. To ensure compliance the Administrator or Designee will responsible to complete the G monitoring tool weekly for 4 weeks, then monthly x 6 mont Results will be presented to th QA committee.	ately ining d by n an d be d A	

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. E	2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS CITY STATE ZIP CODE			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP CO 5TH STREET ERSVILLE, IN 47331	DE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETIC	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE	
	roles. (ii) Provide er training at least ev (iii) Maintain of emergency prepara (iv) Demonstr emergency proceed (v) If the emergency proceed (v) If the emergency proceed updated, the [facil on the updated procedure *[For Hospices at The hospice must (i) Initial training preparedness poling new and existing from arrangement, con- roles. (ii) Demonstrate emergency procedure (iii) Provide entraining at least ev (iv) Periodical emergency preparate employees (includy with special emphilthe procedures nerging and others. (v) Maintain of emergency preparate (vi) If the emergency preparate (vi) If th	documentation of all redness training. rate staff knowledge of dures. rgency preparedness edures are significantly ity] must conduct training policies and procedures. §418.113(d):] (1) Training. do all of the following: ng in emergency cies and procedures to all nospice employees, and oviding services under sistent with their expected ate staff knowledge of dures. mergency preparedness very 2 years. Ily review and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out ecessary to protect patients						

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS_CITY_STATE_ZIP_CODE			(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET		
	FIC CARE OF CONN				RSVILLE, IN 47331		I
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETIC DATE
	preparedness poli new and existing s services under volunteers, consis roles. (ii) After initial emergency prepar years. (iii) Demonstr emergency proced (iv) Maintain of emergency prepar (v) If the eme policies and proce updated, the PRT the updated p *[For LTC Facilitie Training Program. all of the following (i) Initial traini preparedness poli new and existing s services under volunteers, consis role. (ii) Provide en training at least ar (iii) Maintain of emergency prepar (iv) Demonstr emergency proced *[For CORFs at §4 The CORF must of (i) Provide init	documentation of all redness training. rgency preparedness dures are significantly F must conduct training on policies and procedures. s at §483.73(d):] (1) The LTC facility must do : ng in emergency cies and procedures to all staff, individuals providing er arrangement, and tent with their expected mergency preparedness mually. documentation of all redness training. ate staff knowledge of dures. 485.68(d):](1) Training. lo all of the following: tial training in emergency cies and procedures to all					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	, ,	JILDING NG	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETIC DATE
	and volunteers, co roles. (ii) Provide er training at least ev (iii) Maintain o training. (iv) Demonstr emergency procee must be oriented a responsibilitie emergency plan w workday. The train instruction in the le systems and signa equipment. (v) If the em policies and proce updated, the COR the updated p *[For CAHs at §48 program. The CAH following: (i) Initial traini preparedness poli including prompt r of fires, protection evacuation of pati guests, fire preven firefighting an new and existing a services under arr volunteers, co roles. (ii) Provide er training at least ev (iii) Maintain o	documentation of the rate staff knowledge of dures. All new personnel and assigned specific res regarding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting regency preparedness edures are significantly F must conduct training on policies and procedures. 85.625(d):] (1) Training H must do all of the ng in emergency cies and procedures, eporting and extinguishing on, and where necessary, ents, personnel, and ntion, and cooperation with d disaster authorities, to all staff, individuals providing rangement, and posisistent with their expected mergency preparedness					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 03/16/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ET ADDRESS, CITY, STATE, ZIP CODE E 5TH STREET			
MAJES	FIC CARE OF CON	NERSVILLE		NERSVILLE, IN 47331			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	<ul> <li>policies and procupdated, the CAI the updated</li> <li>*[For CMHCs at The CMHC must emergency prepare procedures to all individuals provid arrangement, and their expected rod documentation of must demonstrate emergency proced CMHC must prove preparedness train includes a training must do all of the emergency preparedness train includes a training must do all of the emergency preparedness train includes a training must do all of the emergency preparedness train includes a training must do all of the emergency preparedness train includes a training must do all of the emergency preparedness train includes a training to all new and exist services under arra consistent with the emergency preparedness train annually; (iii) Mai training; (iv) Dem emergency proceed CFR 483.73(d)(1) affect all occupant Findings include:</li> </ul>	nergency preparedness bedures are significantly H must conduct training on policies and procedures. §485.920(d):] (1) Training. provide initial training in aredness policies and new and existing staff, ding services under d volunteers, consistent with les, and maintain f the training. The CMHC te staff knowledge of edures. Thereafter, the vide emergency uning at least every 2 years. eview and interview, the asure the emergency ing and testing program program. The LTC facility following: (i) Initial training in edness policies and procedures sting staff, individuals providing angement, and volunteers, eir expected roles; (ii) Provide edness training at least ntain documentation of the onstrate staff knowledge of ures in accordance with 42 . This deficient practice could s.	E 0037	<ol> <li>The allegation is that the facility failed to show staff to on the emergency prepare program documentation for recent twelve month period not available.</li> <li>No residents were affect other residents had the polybe at risk by this deficient practice.</li> <li>The Administrator immendation.</li> <li>To ensure compliance to Maintenance Director or Designee will be responsible complete the QA monitorin weekly for 4 weeks, then mix 6 months. Results of augmindings will be presented to QA committee.</li> </ol>	raining dness most was ted but ential to ediately aining dness he le to g tool oonthly dit	04/19/202	

STATEME	NT OF DEFICIENCIES OF CORRECTION				X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			
	PROVIDER OR SUPPLIEF			1029 E	ADDRESS, CITY, STATE, ZIP COE 5TH STREET ERSVILLE, IN 47331	θE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	LD BE	(X5) COMPLETIO DATE	
5 0039 SS=F Bldg	documentation for a preparedness within month period was r Based on interview the Executive Direct the emergency prep documentation with month period was r time of the survey. This finding was ree Director and the Ma the exit conference. 403.748(d)(2), 414 441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi *[For RNCHI at §4 HHAs at §484.102 "Organizations" u §485.920, RHC/F Facilities at §494. (2) Testing. The [fac following: (i) Participate is community-bas (A) When exercise is not ac facility-based fund years; or (B) If the actual natural or r	thin the most recent twelve toot available for review at the viewed with the Executive aintenance Director during 6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 403.748, ASCs at §416.54, 2, CORFs at §485.68, OPO, nder §485.727, CMHC at QHC at §491.12, ESRD 62]: acility] must conduct he emergency plan ility] must do all of the in a full-scale exercise that ed every 2 years; or in a community-based cessible, conduct a ctional exercise every 2						

STATEME	S FOR MEDICARE & MEDICAID SERVICES         EMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155491			MULTIPLE CO BUILDING WING	03/	OMB NO. 0938-035 (X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			1029 E	ADDRESS, CITY, STATE, ZIP CO 5TH STREET ERSVILLE, IN 47331	ODE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH	OULD BE	COMPLETIC
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
	plan, the [fac	lity] is exempt from					
	engaging in its ne	xt required					
	community-based	or individual, facility-based					
	func	tional exercise following the					
	onset of the actua	l event.					
	(ii) Conduct a	n additional exercise at					
		s, opposite the year the					
		onal exercise under					
		(2)(i) of this section is					
		ay include, but is not					
	limited to the follo	0					
		cond full-scale exercise that					
	is community-bas						
	-	tional exercise; or					
		ck disaster drill; or					
	• •	letop exercise or workshop					
		ilitator and includes a					
	group discussion	vant emergency scenario,					
	-	em statements, directed					
	messages, or pre						
		hallenge an emergency					
	plan.	hallenge an emergency					
		ze the [facility's] response					
		ocumentation of all drills,					
	tabletop exercises	,					
		evise the [facility's]					
	emergency plan, a	as needed.					
	*[For Hospices at	418.113(d):]					
		spices that provide care in					
		e. The hospice must					
		to test the emergency plan					
	-	The hospice must do the					
	following:						
	.,	e in a full-scale exercise					
	-	based every 2 years; or					
		n a community based					
		cessible, conduct an					
		ased functional exercise					

STATEME	NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '	UILDING		COMPLE	
	155491		B. W	/ING		03/16/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	E	
	PROVIDER OR SUPPLIE				5TH STREET		
MAJEST	IC CARE OF CON	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	<sup>×</sup>	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		years; or					
	. ,	e hospice experiences a					
		ade emergency that					
		n of the emergency plan,					
		is exempt from engaging in					
		full scale community-based					
	exercise or indivi	-					
	functional exercise	se following the onset of the					
	emergency even	t.					
	(ii) Conduct	an additional exercise every					
	2 years, opposite	the year the full-scale or					
	functional exercis	se under paragraph (d) (2)					
	(i) of this section	is conducted, that may					
	include, but is no	t limited to the following:					
	(A) A s	econd full-scale exercise that					
	is community-ba	sed or a facility based					
	functional exercis	se; or					
	(B) A m	nock disaster drill; or					
	(C) A ta	abletop exercise or workshop					
	that is led by a fa	cilitator and includes a					
	group discussion	using a narrated,					
	clinically-rele	evant emergency scenario,					
	and a set of prob	lem statements, directed					
	messages, or pre	epared questions					
	designed to	challenge an emergency					
	plan.						
	(3) Testing for he	spices that provide inpatient					
	•	e hospice must conduct					
	-	the emergency plan twice					
		spice must do the following:					
		te in an annual full-scale					
		ommunity-based; or					
		en a community-based					
	. ,	ccessible, conduct an					
		facility-based functional					
	exercise	•					
		e hospice experiences a					
	. ,	ade emergency that					
		n of the emergency plan,					
		in or the emergency plan,					

	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER: 155491		A.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETIC DATE	
	its next required fu or facility-based fu exercise follo emergency event. (ii) Conduct a exercise that may to the following: (A) A se is community-bas functional exercise (B) A ma (C) A tal led by a facilitator discussion using a clinically-relevant and a set of proble messages, or pre- designed to co plan. (iii) Analyze fa and maintain docu tabletop exercises and revise the plan, as needed. *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises twice per year. The must do the follow (i) Participate exercise is not acc annual individual, exercise (B) If the	wing the onset of the an additional annual include, but is not limited cond full-scale exercise that ed or a facility based e; or ock disaster drill; or obletop exercise or workshop that includes a group a narrated, vant emergency scenario, em statements, directed oared questions thallenge an emergency the hospice's response to umentation of all drills, s, and emergency events e hospice's emergency et hospice's or more the emergency plan the [PRTF, Hospital, CAH] must to test the emergency plan the [PRTF, Hospital, CAH] ring: e in an annual full-scale ommunity-based; or in a community-based cessible, conduct an facility-based functional						

STATEME	R MEDICARE & MEDICAID SERVICES         VT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         OF CORRECTION       IDENTIFICATION NUMBER:         155491			MULTIPLE CO BUILDING WING	(X3) DA COM 03/	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			1029 E	ADDRESS, CITY, STATE, ZIP CO 5TH STREET ERSVILLE, IN 47331	ODE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH	OULD BE	COMPLETIC
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
	emergency that re	equires activation of					
	the emergend	cy plan, the [facility] is					
	exempt from enga	aging in its next required					
	full-scale commun	nity based or					
	individual, fac	cility-based functional					
	exercise following	the onset of the					
	emergency event.						
	(ii) Conduct a	n [additional] annual					
	exercise or and th	exercise or and that may include, but is not					
	limited to the follo	wing:					
	(A) A see	cond full-scale exercise that					
	is community-base	ed or individual, a					
	facility-based fund	tional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tab	letop exercise or workshop					
		cilitator and includes a					
	group discussion,	-					
		vant emergency scenario,					
		em statements, directed					
	messages, or pre						
	designed to c	hallenge an emergency					
	plan.						
		he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	and revise the	e [facility's] emergency					
	plan, as needed.						
	*[For LTC Facilitie	, -					
		ty] must conduct exercises					
	•	ency plan at least twice per					
	-	announced staff drills					
	• •	ncy procedures. The [LTC					
		ust do the following:					
	.,	e in an annual full-scale					
		ommunity-based; or					
		n a community-based					
		cessible, conduct an					
		facility-based functional					
	exercise	•	1				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. B	IULTIPLE C UILDING /ING	CON	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP 55TH STREET	CODE	
IVIAJES					IERSVILLE, IN 47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE E APPROPRIATE	COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		[LTC facility] facility					
		tual natural or man-made					
		quires activation of the					
	-	cy plan, the LTC facility is					
		ging its next required a					
	full-scale commun	-					
		ility-based functional					
	exercise following						
	emergency event.						
	. ,	an additional annual					
		include, but is not limited					
	to the following:						
	• • •	cond full-scale exercise that					
	-	ed or an individual, facility					
	based functional e						
	• • •	ock disaster drill; or					
		pletop exercise or workshop					
		ilitator includes a group					
	discussion, using						
		/ant emergency scenario,					
		em statements, directed					
	messages, or prep	-					
		hallenge an emergency					
	plan.						
		he [LTC facility] facility's					
		naintain documentation of					
	all drills, tabletop						
		the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	483.475(d)]:					
		CF/IID must conduct					
		ne emergency plan at least					
		e ICF/IID must do the					
	following:						
		in an annual full-scale					
		mmunity-based; or					
		n a community-based					
		cessible, conduct an					
		facility-based functional					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		. ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155491	B. V	/ING		03/	16/2021	
NAME OF	PROVIDER OR SUPPLIE	P		STREET A	ADDRESS, CITY, STATE, ZIP (	CODE		
					5TH STREET			
MAJEST	IC CARE OF CON	NERSVILLE		CONNE	RSVILLE, IN 47331			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	exercise							
		e ICF/IID experiences an						
		man-made emergency that						
	requires activation	n of the emergency						
	plan, the ICF	F/IID is exempt from						
		ext required full-scale						
		d or individual, facility-						
	based functi	onal exercise following the						
	onset of the eme	rgency event.						
		an additional annual						
	exercise that may	y include, but is not limited						
	to the following:							
	(A) A se	cond full-scale exercise that						
	is community-bas	sed or an individual,						
	facility-based fun	ctional exercise; or						
	(B) A m	ock disaster drill; or						
	(C) A ta	bletop exercise or workshop						
	that is led by a fa	cilitator and includes a						
	group discussion	, using a narrated,						
	clinically-rele	evant emergency scenario,						
	and a set of prob	lem statements, directed						
	messages, or pre designed to	epared questions challenge an emergency						
	plan.							
	(iii) Analyze	the ICF/IID's response to						
	and maintain doo	cumentation of all drills,						
	tabletop exercise	s, and emergency events,						
	and revise the	ne ICF/IID's emergency plan,						
	as needed.							
	*[For OPOs at §4	86 3601						
		ne OPO must conduct						
		the emergency plan. The						
	OPO must do the							
		a paper-based, tabletop						
	.,	shop at least annually. A						
		is led by a facilitator and						
		roup discussion, using a						
		y relevant emergency						
		set of problem statements,						
		,						

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155491		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	OMB NO. 0938-039 [X3] DATE SURVEY COMPLETED 03/16/2021					
NAME OF PROVIDER OR SUPPLIER			1029	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331					
X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES 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			
	emergency plan. actual natural of requires activatio the OPO is exem required test onset of the emer (ii) Analyze th maintain docume exercises, and er the [RNHCI's plan, as needed. Based on record re facility failed to co emergency plan at unannounced staff procedures. The L following: (i) partie that is community- community-based of individual, facility- experiences an actu emergency plan, the engaging in a comm facility-based full-st following the onset conduct an addition but is not limited to	he OPO's response to and ntation of all tabletop nergency events, and revise and OPO's] emergency view and interview, the nduct exercises to test the least annually, including drills using the emergency TC facility must do all of the cipate in a full-scale exercise	E 0039	<ol> <li>The allegation is that the facility did not have any documentation for communit based disaster drill or table to exercise conducted within the most recent twelve month pe</li> <li>No resident was affected residents had the potential to risk by this deficient practice.</li> <li>The Administrator immediate started table top exercises we staff.</li> <li>To ensure compliance the Administrator or Designee wiresponsible to complete the of monitoring tool weekly for 4 weeks, then monthly x 6 more poeulte of audit will be preserved.</li> </ol>	pp e vriod. but b be at iately ith ith ill be QA nths.	04/19/2021			

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

full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise

that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the

Event ID:

VZOT21 Facility ID: 000316

Results of audit will be presented

to the QA committee.

If continuation sheet

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, documentation of community based disaster drills or table top exercise conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the facility is currently experiencing the Covid-19 pandemic disaster but agreed documentation for an additional community based disaster drill or a table top exercise conducted within the most recent twelve month period was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. K 0000 Bldg. 05 A Life Safety Code Preoccupancy survey was K 0000 conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The renovation in Building 05 is for the remodeling resident rooms in the 400 and (formerly unlicensed) 500 wing of the east building into a dedicated ventilator unit (four semi-private and six private resident rooms), to include the remodeling a former medication room into an oxygen storage room, a soiled holding room into a bathing room, an office into a dining and FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 35 of 81

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE activity room, a reception area and storage rooms into a nurse station and medication room, and three other rooms into a corridor, two laundry rooms (soiled and clean), and a mechanical room. Vent unit will be Rooms 401, 402, 409, and 410 each with two (2) licensed beds and rooms 403, 404, 405, 406, 407, and 408 each with one (1) licensed bed, for a total of fourteen (14) Vent beds. Remodeling in the 200 Wing of a medication room, a nurse station, and a closet into a resident lounge and a mechanical closet; a storage room and a linen closet into two mechanical rooms. Conversion of the 100 unit and portions of the 200 unit into a single locked unit; to include reconfiguring a common space for the south wing and a public lobby outside the units to connect the two corridors; converting a medications room, a soiled utility room, and a clean utility room into a reception desk; a clean utility room, a soiled utility room, and a mechanical closet. Also included is remodeling of a closet to enlarge a nurse station; a nurse station and an office into a staff breakroom; an entrance alcove into a receiving room and storage area; and adding a service counter to an existing dining room. There was also a reconfiguring of two bathing rooms and adjacent closet into mechanical rooms. Locked unit will be rooms 101-115, 201-213, 301-317. Renumbering of rooms in this building to accommodate construction changes. General remodeling of office and support areas, replacement of HVAC systems throughout, and replacement of the generator and automatic transfer switches to provide a Type-1 essential electrical system (EES) for the ventilator wing. Survey Date: 03/16/21 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 36 of 81

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTI A. BUILDI B. WING	PLE CONSTRUNG 05		(X3) DATE SURVEY COMPLETED 03/16/2021	
NAME OF PROVIDER OR SUPPLIER			10	29 E 5TH 3	ss, city, state, zip code STREET ILLE, IN 47331		
	1					(¥5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	PREFIX (EACH		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIC	
TAG		LSC IDENTIFYING INFORMATION)	TA	CRO	DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
	Connersville was for Requirements for F Medicare/Medicard Life Safety from Fi National Fire Prote 101, Life Safety Co Existing Health Ca 16.2. The renovate	155491 286370 cy survey, Majestic Care of bund not in compliance with					
	buildings, the East Building, which we (111) construction sprinkled. The East except for the newl transfer switch root building. Each bui with smoke detection open to the corrido	ed of two, one story Building and the West ere determined to be of Type V and the West Building is fully t Building is fully sprinklered y constructed automatic n which is attached to the Iding has a fire alarm system on in the corridors and spaces r. The facility has a capacity msus of 70 at the time of this					
	were sprinkled and services were sprin constructed automa which is attached to	-					
0100 SS=E	Quality Review con NFPA 101 General Requirer	npleted on 03/23/21					

PRINTED: 04/12/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) Bldg. 05 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility K 0100 1. The allegation is the the 04/19/2021 latching hardware at the top and failed to maintain latching hardware on 1 of 6 sets of smoke barrier doors in accordance with the bottom of the south door in the 200 hall failed to latch into the 4.6.12.3. LSC 4.6.12.3 requires existing life

Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the following was noted: a. the latching hardware at the top and the bottom of the south door in the corridor door set in the 200 Hall failed to latch into the door frame when tested to close multiple times. The latching hardware on the door failed to protrude into the latching plate on the door frame and on the floor. b. the corridor door to the 400 Hall electrical room was equipped with a self closing device but the device was partially disconnected which prevented the door from self closing and latching into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors would not latch into the door frame when tested to close multiple times.

safety features obvious to the public if not

required by the Code, shall be either maintained

or removed. This deficient practice could affect

over 20 residents, staff and visitors in the 200

Based on observations with the Maintenance

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

Hall.

Findings include:

Event ID:

VZOT21

Facility ID: 000316

the QA committee.

door frame. The latching

hardware on the door failed to

protrude into the latching plate on

the door frame and on the floor.

Plus the corridor door to the 400 hall electrical room was equipped with a self closing device but the

device was partially disconnected

and it prevented the self closing

and latching door to not latch. 2. No residents were affected.

No residents live in this area of

3. The Maintenance Director

immediately fixed these problems

by readjusting the door latches.

Designee will be responsible to

complete the QA monitoring tool

daily Monday-Friday for 2 weeks,

monthly for 3 months. Results of

audit findings will be presented to

then weekly for 4 weeks, then

4. To ensure compliance the

Maintenance Director or

the LTC.

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

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155491	A. BUILDING <u>05</u> B. WING			COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE		 1029 E	ADDRESS, CITY, STATE, ZIP COI 5TH STREET ERSVILLE, IN 47331	DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY 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 APP DEFICIENCY)	II D BE	(X5) COMPLETION DATE	
		eviewed with the Executive laintenance Director during e.					
	3.1-19(b)						
K 0161 SS=F Bldg. 05	Building Constru 2012 EXISTING Building construct						
		ction Type I (332), II (222) Any number non-sprinklered and					
	2 II (111) non-sprinklered	One story Maximum 3 stories					
	sprinklered	Maximum 3 stories					
	3 II (000) non-sprinklered	Not allowed					
	4 III (211) sprinklered 5 IV (2H⊢ 6 V (111)						
	7 III (200) non-sprinklered						
	8 V (000) sprinklered Sprinklered storie	Maximum 1 story es must be sprinklered					
		approved, supervised					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES S EOD MEDICADE & MEDICAID SEDVI

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491		(X2) MULTIPLE C A. BUILDING B. WING	<u>05</u>	(X3) DATE SURVEY COMPLETED 03/16/2021			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE		
	<ul> <li>9.7. (See 19.3.5)</li> <li>Give a brief descriconstruction, the basements, floors located, location of and dates of apprattach small floor appropriate.</li> <li>Based on observatif failed to maintain the construction type of in 1 of 1 automatic East Building. This affect all residents, Building.</li> <li>Findings include:</li> <li>Based on observatif Director during a transmet of the servatif of the observation of the</li></ul>	eviewed with the Executive aintenance Director during	К 0161	<ol> <li>The allegation is that the facility did not make available the review for the fire resistance rating for the wood in the automatic transfer switch room attached to building outside the 400 hall dining room.</li> <li>Arch/Engineer interpretation of code requirements for exterior attached ATS room to existing structure with existing min (1) h fire rating on interior walls (dining/mech/clean linen).</li> <li>No residents were affected, other residents in those areas h the potential to be at risk by this deficient practice.</li> <li>Installed type X fire rated (4I drywall to ATS room wall studs and roof rafters with (2) mud coats over screws and taped joints.</li> <li>To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring too daily for 2 weeks, weekly 4 weeks, and monthly for 3 month Facility Maintenance to conduct structural integrity inspection of ATS room during</li> </ol>	r aad s nr)		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING			(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE		10	REET ADDRESS, CITY, STATE, ZIP 29 E 5TH STREET ONNERSVILLE, IN 47331	CODE		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO DATE	
				routine/scheduled ma procedures/inspection of audit findings will b to the QA committee. Title of person respor implementing accepta Project Manager/Faci Maintenance Dept.	ns. Results e presented nsible for able POC:		
< 0222 SS=E Bldg. 05	not be equipped w requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special loc clinical security ne used, only one loc permitted on each be made for the ra by: remote contro locks or keys carr other such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of th the Clinical or Sec are being met. In electrical locks that	S OR SECURITY THREAT king arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all ied by staff at all times; or e means available to the .2.2.6, 19.2.2.2.5.1, CLOCKING S king arrangements for the 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					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	R: A. BUILDING B. WING		05	COMP	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,		(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E RIATE	COMPLETIC	
IAG		er system and the locked		IAG	DEFICIENCIT		DATE	
	space is protected detection system at an attended lo space); and both systems are arra upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed systems installed 7.2.1.6.1 shall be assemblies servi contents in buildi an approved, sup detection system automatic sprinkl 18.2.2.2.4, 19.2.2 ACCESS-CONTI LOCKING ARRA Access-Controlle installed in accor be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOE LOCKING ARRA Elevator lobby ex accordance with on door assembl throughout by an automatic fire det approved, superv system. 18.2.2.2.4, 19.2.2	d by a complete smoke (or is constantly monitored cation within the locked the sprinkler and detection nged to unlock the doors 2.2.2.5.2, TIA 12-4 ESS LOCKING TS delayed-egress locking in accordance with epermitted on door ng low and ordinary hazard ngs protected throughout by pervised automatic fire or an approved, supervised er system. 2.2.4 ROLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall 2.2.4 BY EXIT ACCESS NGEMENTS sti access door locking in 7.2.1.6.3 shall be permitted ies in buildings protected approved, supervised tection system and an vised automatic sprinkler 2.2.4	KO	222	1 The allegation is that the	exit	04/19/20	
	facility failed to er through 2 of 3 exit accessible for resid	vation and interview, the asure the means of egress is in the 400 Hall were readily dents without a clinical g specialized security	K 0	222	<ol> <li>The allegation is that the door by the Nurses Station of 400 hall was not equipped w signage indicating the door of be opened after pushing for</li> </ol>	on the rith could	04/19/20	

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

	EDICARE & MEDIC						MB NO. 0938-039
	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION		E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		ILDING	05	COMPLETED 03/16/2021	
		155491	B. WI	NG			
JAME OF PRO	VIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP COD	E	
and of the		n in the second s		1029 E	5TH STREET		
MAJESTIC	CARE OF CON	NERSVILLE		CONN	ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	D BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
r	neasures. Doors v	within a required means of			seconds.		
	-	equipped with a latch or lock			2. No residents, staff or v		
	-	se of a tool or key from the			were affected, but resider	nts had	
	-	otherwise permitted by LSC			the potential to be at risk	by this	
1	9.2.2.2.4. Door-l	ocking arrangements shall be			deficient practice.		
F	permitted in accord	dance with 19.2.2.2.5.2. This			3. The Maintenance Dire	ctor	
Ċ	leficient practice c	could affect over 14 residents,			immediately had signage	ordered	
s	staff and visitors if	needing to exit the 400 Hall.			and placed at 400 hall ex	it door.	
					Signage has been placed		
I	Findings include:				4. To ensure compliance	the	
					Maintenance Director or		
I	Based on observati	ions with the Maintenance			Designee will be responsi	ble to	
I	Director during a t	our of the facility from 10:40			complete the QA monitor	ng tool	
а	a.m. to 2:30 p.m. on 03/16/21, the west exit in daily Monday- Friday for 4		1 weeks,				
ť	he 400 Hall by the	e dining room and the exit door			then weekly for 4 weeks, the		
s	set in the corridor	by the 400 Hall oxygen			monthly for 3 months.		
s	storage room were	both marked as a facility exit,			Passive inspection by Ma	int./staff	
v	were magnetically	locked and could be opened			to ensure signage remain	s	
ł	by entering a four	digit code but the code was not			posted. Scheduled regula	itory	
ŗ	osted. Based on i	interview at the time of the			inspections.		
c	observations, the N	Aaintenance Director agreed					
ť	he aforementioned	d doors were marked as a					
f	acility exit and co	uld be opened by entering a					
f	our digit code but	the code was not posted.					
	÷	eviewed with the Executive					
		laintenance Director during					
t	he exit conference						
3	3.1-19(b)						
	Based on observ	vation and interview, the					
		sure the means of egress					
	-	ayed egress locks were readily					
	-	esidents, staff and visitors.					1
		ayed Egress Locks allows					
		elayed egress locks shall be					
		talled on doors serving low					
-		d contents in buildings					
	-	but by an approved, supervised					
ŀ	A Steered infought	at 53 un approved, supervised					

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Event ID: VZOT21 Facility ID: 000316

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 05 IJ55491 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE				(X3) DATE SURVEY COMPLETED 03/16/2021		
	NAME OF PROVIDER OR SUPPLIER			STREET AI 1029 E 5 CONNEI	3		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETIO
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	automatic fire detec	tion system installed in					
	accordance with Se	ction 9.6, or an approved,					
		ic sprinkler system installed					
	-	Section 9.7, and where					
		ers 12 through 42, provided:					
		k upon actuation of an					
		ed automatic sprinkler system					
		nce with Section 9.7, or upon					
		heat detector or not more					
		ectors of an approved,					
		ic fire detection system					
	·	nce with Section 9.6.					
		k upon loss of power					
		or locking mechanism.					
	-	process shall release the lock					
		pon application of a force to					
		equired in 7.2.1.5.4 that shall					
		xceed 15 lbf nor required to					
	-	blied for more than 3 seconds.					
		e release process shall					
		signal in the vicinity of the					
		or lock has been released by					
		orce to the releasing device,					
		y manual means only.					
	-	pproved by the authority					
	-	a delay not exceeding 30					
	seconds shall be per	rmitted.					
	(d) On the door adj	acent to the release device,					
		lily visible, durable sign in					
		1 inch high and at least 1/8					
		on a contrasting background					
	that reads:						
	"PUSH UNTIL AL	ARM SOUNDS.					
	DOOR CAN BE O	PENED IN 15 SECONDS".					
	This deficient pract	ice could affect over 14					
		visitors if needing to exit the					
	Findings include:						

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING			(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			1029 E	.DDRESS, CITY, STATE, ZIP C 5TH STREET RSVILLE, IN 47331	CODE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	-	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	COMPLETIC	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE	
	Based on observation	ons with the Maintenance						
	Director during a to	our of the facility from 10:40						
	-	103/16/21, the exit door set						
	-	e facility in the 400 Hall by						
		vas marked as a facility exit						
	with an exit sign an	d was locked and was not						
	equipped with sign	age indicating the door could						
	be opened after pus	hing for 15 seconds. The exit						
	door set released to	open after pushing for 15						
		d multiple times. In addition,						
		be opened by entering a four						
	-	ode was not posted. Based on						
		e of the observations, the						
	Maintenance Direct	-						
		t door set at the 400 Hall						
		not equipped with the						
		ndicating the door set could						
	be opened after pus	hing for 15 seconds.						
	This finding was re	viewed with the Executive						
		aintenance Director during						
	the exit conference.							
	3.1-19(b)							
	5.1-19(0)							
0321	NFPA 101							
SS=E	Hazardous Areas	- Enclosure						
Bldg. 05	Hazardous Areas							
		are protected by a fire						
	•	our fire resistance rating						
	``	rated doors) or an						
		nguishing system in						
		3.7.1 or 19.3.5.9. When the						
		tic fire extinguishing system						
		e areas shall be separated						
		by smoke resisting rs in accordance with 8.4.						
	Doors shall be se							
		and permitted to have						
		applied protective plates						
		TELES PLEISOULO PIOLOO					1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BUILDING B. WING	construction <u>05</u>	(X3) DATE SURVEY COMPLETED 03/16/2021			
	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331					
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O that do not excee of the door.	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ed 48 inches from the bottom r and zone locations of	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETI DATE		
	hazardous areas REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fue b. Laundries (larg c. Repair, Mainte d. Soiled Linen R gallons) e. Trash Collectio (exceeding 64 ga f. Combustible Si (over 50 square f g. Laboratories (i Hazard - see K32 1. Based on observe facility failed to er areas such as fuel separated from oth partitions and door or automatic closin This deficient prace residents, staff and Findings include: Based on observat Director during a t a.m. to 2:30 p.m. of the 200 Hall nature the entry door to th 223, which is inside were not equipped Room 223 also con	Automatic Sprinkler N/A A-Fired Heater Rooms ger than 100 square feet) nance, and Paint Shops cooms (exceeding 64 on Rooms allons) torage Rooms/Spaces feet) f classified as Severe 22) vation and interview, the asure 3 of over 10 hazardous fired heater rooms were er spaces by smoke resistant rs. Doors shall be self closing ing in accordance with 7.2.1.8. tice could affect over 20	K 0321	<ol> <li>The allegation is that door to the 200 hall furna and the entry door to roo were not equipped with a closing device. Room 22 openings in the wall and which did not separate th from other spaces with s resistant partitions. Self of device in the 400 hall sel device failed to latch. Scott door was notified th custom fit door would be as soon as possible.</li> <li>No residents were aff had the potential to be at this deficient practice.</li> <li>The Maintenance Dire immediately patched and</li> </ol>	ace room om 223 a self 23 had ceiling ne room moke closing f closing nat a new needed ected but t risk by ector	04/09/20		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 05 COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) openings in the wall and ceiling of the room caulked the openings. all self which did not separate the room from other closing devices were fixed. 4. To ensure compliance the spaces with smoke resistant partitions: Maintenance Director or a. a twelve inch by two inch hole in the east wall Designee will be responsible to of the room. b. a three inch by one inch rectangular shaped complete the QA monitoring tool hole in the west wall of the room near the floor. every day for 4 weeks, every week for 4 weeks, and every ac. the annular space surrounding a two inch in diameter PVC pipe which penetrated the west month for 3 months. wall of the room. d. the annular space surrounding a three inch in diameter PVC pipe for the furnace exhaust or fresh air intake which penetrated the ceiling of the room. e. the hole next to the ceiling mounted sprinkler in the room. In addition, the entry door to the natural gas fired furnace room inside the 100 Hall Bathing room had a one and three quarters inch gap between the bottom of the door and floor. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous areas such as laundries (greater than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 47 of 81

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	Г OF HEALTH AND HU R MEDICARE & MEDI					RM APPROVED B NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CC A. BUILDING B. WING	05	(X3) DATE SURVEY COMPLETED 03/16/2021	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE 5TH STREET		
MAJEST	IC CARE OF CON	NERSVILLE		ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	) BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	rooms.	laundry and clean utility				
	Findings include:					
	Based on observat	ions with the Maintenance				
	-	our of the facility from 10:40				
	-	on $03/16/21$ , the corridor door				
	to the soiled Laundry room in the 400 Hall and the corridor door to the Clean Utility room in					
		each equipped with a self				
	-	each door failed to latch into				
	the door frame when tested to close multiple					
	times. Based on interview at the time of the observations, the Maintenance Director agreed					
		d hazardous area's corridor				
		sist the passage of smoke and				
	did not self close a	and latch into the door frame				
	when tested to close	se multiple times.				
	This finding was r	eviewed with the Executive				
	-	faintenance Director during				
	3.1-19(b)					
<b>C</b> 0331	NFPA 101					
SS=F	Interior Wall and	-				
Bldg. 05	Interior Wall and	Ceiling Finish				
	2012 EXISTING	ceiling finishes, including				
		surfaces of buildings such				
	as fixed or mova	ble walls, partitions,				
		ve a flame spread rating of				
		B. The reduction in class of				
		a sprinkler system as 2.8.1 is permitted.				
	10.2, 19.3.3.1, 19					
	Indicate flame sp					

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Event ID: VZOT

VZOT21 Facility ID: 000316

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number: 155491	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>05</u>	(X3) DATE SURVEY COMPLETED <b>03/16/2021</b>	
	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331			
MAJESTI (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF Based on observati failed to ensure one switch rooms in the with a complete int spread rating of CL sprinklered facility products required t ASTM E 84, Stand Burning Characteri ANSI/UL 723, Sta Burning Characteri shall be grouped in accordance with the development. (a) Class A Interior Flame spread 0-25; Includes any mater the flame spread te smoke test scale. A tested, shall not coor (b) Class B Interior Flame spread 26-7; Includes any mater but not more than 7 scale and 450 or le (c) Class C Interior Flame spread 76-20 0-450. Includes an than 75 but not mo spread test scale an test scale. This deficient prac staff and visitors in Findings include:	TATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION) on and interview, the facility e of one automatic transfer e East Building was provided erior finish with a flame ass A or Class B for a . LSC 10.2.3.4 states o be tested in accordance with ard Test Method for Surface stics of Building Materials or ndard for Test for Surface stics of Building Materials the following classes in eir flame spread and smoke Wall and Ceiling Finish. smoke development 0-450. ial classified at 25 or less on st scale and 450 or less on the ny element thereof, when so ntinue to propagate fire. Wall and Ceiling Finish. 5; smoke development 0-450. ial classified at more than 25 75 on the flame spread test ss on the smoke test scale. Wall and Ceiling Finish. 0; smoke development y material classified at more tre than 200 on the flame d 450 or less on the smoke tice could affect all residents,	CONNI ID PREFIX TAG K 0331	ERSVILLE, IN 47331  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)  1. The allegation is that the building outside the 400 hal room consisted of particle b and wood studs. no flame a rating was printed on the we 2. No residents wee affected had the potential to be at rist this deficient practice. 3. Type X fire rated drywall ATS room walls and ceiling Applied intumescet (fire reta paint over north wall of ATS Drywall & intumescent pain Class A rating. 4. To ensure compliance th Maintenance Director or "Designee will be responsite complete the QA monitoring every day for 4 weeks, every me 3 months. All findings will b presented to QA committee Facility Maintenance to con structural integrity inspection ATS room during routine/scheduled maintena procedures/inspections. Title of person responsible implementing acceptable P Project Manager/Facility Maintenance Dept.	Be completion DATE DATE DATE DATE DATE DATE DATE DATE	
	Director during a to a.m. to 2:30 p.m. o	our of the facility from 10:40 n 03/16/21, all interior walls of the roof of the newly				

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Event ID: VZOT21 Facility ID: 000316

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	ERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(Y2)		NSTRUCTION		OMB NO. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 155491	A. I	A. BUILDING <u>05</u> B. WING		COMPLETED 03/16/2021	
NAME OF	PROVIDER OR SUPPLIEF	1			DDRESS, CITY, STATE, ZIP	CODE	
MAJES	TIC CARE OF CONN	IERSVILLE			5TH STREET RSVILLE, IN 47331		
(X4) ID	SUMMARY S	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT		ORRECTION	(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO DATE
: 0351 SS=F Bldg. 05	attached to the build dining room consists wood studs. The fl- was not printed on the for review. In addit Hall mechanical root to the wall from the affixed flame spread Based on interview observations, the M the room was newly new transfer switch documentation for the review and he was the treated with a flame This finding was ree Director and the Ma the exit conference. 3.1-19(b) NFPA 101 Sprinkler System Spinkler System - 2012 EXISTING Nursing homes, a by construction ty throughout by an sprinkler system in 13, Standard for the Systems. In Type I and II con protection measure substituted for spri areas where state prohibit sprinklers In hospitals, sprin	<ul> <li>aintenance Director stated</li> <li>y constructed to house the</li> <li>es, the flame spread rating</li> <li>he wood was not available for</li> <li>not aware if the wood had been</li> <li>e retardant material.</li> <li>viewed with the Executive</li> <li>aintenance Director during</li> </ul> - Installation Installation Ind hospitals where required pe, are protected approved automatic n accordance with NFPA ne Installation of Sprinkler enstruction, alternative res are permitted to be inkler protection in specific or local regulations					

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

PRINTED: 04/12/2021 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
AND PLAN	OF CORRECTION		B. WING	<u>05</u>		
		155491	B. WING		03/16/2021	
NAME OF	PROVIDER OR SUPPLIE	B	STREET	ADDRESS, CITY, STATE, ZIP CODE		
101012-01			1029 E	5TH STREET		
MAJEST	TIC CARE OF CONI	NERSVILLE	CONN	ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	where the area of	the closet does not exceed				
	6 square feet and	sprinkler coverage covers				
	the closet footprin	nt as required by NFPA 13,				
	Standard for Insta	allation of Sprinkler				
	Systems.					
	19.3.5.1, 19.3.5.2	2, 19.3.5.3, 19.3.5.4,				
		19.3.5.10, 9.7, 9.7.1.1(1)				
		d to ensure 1 of 1 automatic	K 0351	1. The allegation is that the	04/19/2021	
		ms were provided with an		facility did not place a automat		
	· ·	system to ensure sprinkler		sprinkler to the outside building	9	
		tions of the building. This		near the 400 hall dining room.		
	_	ould affect all residents, staff		The escutcheon for the ceiling		
	and visitors in the l	East Building.		mounted sprinkler in the 100 h	all	
				closet in bathing room was		
	Findings include:			missing its escutcheon. A		
				deflector for the upright sprinkl		
		ons with the Maintenance		in 400 hall attic was embedded		
		bur of the facility from $10:40$		the layer of drywall. A hole was		
		n 03/16/21, the newly atic transfer switch room,		noted outside the exit door set		
		the outside of the building		from the 400 hall by nurse's station.		
		Dining Room, was not		Arch/Engineer interpretation of		
		matic sprinklers. Based on		code requirements for exterior		
		ne of the observations, the		attached ATS room to existing		
		tor stated the room was newly		structure with existing		
		of the renovation to		min. (1) hr fire rating on interio	r	
	•	vent unit beds and agreed the		walls (dining/mech/clean linen)		
		automatic transfer switch		2. No residents were affected		
	-	e sprinkler coverage.		had the potential to be at risk b		
				this deficient practice.	-	
	This finding was re	eviewed with the Executive		3. The Maintenance Director h	nad	
		aintenance Director during		Safecare correct the		
	the exit conference	-		findings. Safecare installed		
				sprinkler head in ATS room.Co	over	
	3.1-19(b)			plate was installed over 2" hole	e at	
	3.1-19(ff)			underside of 400 east canopy.		
				Safecare lowered the sprinkler		
	2. Based on observ	ation and interview, the		head that was embedded in (1	)	
		sure 1 of over 100 sprinkler		layer of drywall in the 400 attic		
	heads in the facility were installed in accordance			near south wall at (2) hr		

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Event ID:

VZOT21 Facility ID: 000316

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) with NFPA 13. NFPA 13, Standard for the firewall accessed from clean Installation of Sprinkler Systems, 2010 Edition, laundry room. 4. To ensure compliance the Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers Maintenance Director or Designee will be responsible to shall be part of a listed sprinkler assembly. Section 6.2.7.3 states cover plates used with complete the QA monitoring tool concealed sprinklers shall be part of the listed every day for 4 weeks, every sprinkler assembly. This deficient practice could week for 4 weeks, and every affect over 15 residents, staff and visitors in the month for 3 months. Results of vicinity of the 100 Hall Bathing Room. findings will be presented to the QA committee. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the escutcheon for the ceiling mounted sprinkler in the closet in the 100 Hall Bathing Room was missing its escutcheon. Based on interview at the time of the observations, the Maintenance Director agreed the escutcheon for the aforementioned sprinkler location was missing. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of over 50 attic mounted sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.4.1.2 states under obstructed construction, the sprinkler deflector shall be located in accordance with one of the following arrangements: (1) Installed with the deflectors within the horizontal planes of 1 in. to 6 in. (25.4 mm to FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 52 of 81

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. B	AULTIPLE CO SUILDING VING	DNSTRUCTION 05	CON	(X3) DATE SURVEY COMPLETED 03/16/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIF	P CODE		
MAJEST	IC CARE OF CON	NERSVILLE			5TH STREET ERSVILLE, IN 47331			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)		DATE	
	152 mm) below th	e structural						
	members and a ma	ximum distance of 22 in. (559						
	mm) below the cer	ling/roof deck						
	(2) Installed with t	he deflectors at or above the						
	bottom of the struc	ctural member to a maximum						
	of 22 in. (559 mm)	) below the ceiling/roof deck						
		r is installed in conformance						
	with 8.6.5.1.2 escu	tcheons used with recessed,						
	flush-type or conc	ealed sprinklers shall be part						
	of a listed sprinkle	r assembly.						
	(3) Installed in eac	h bay of obstructed						
	construction, with	the deflectors located a						
	minimum of 1 in.	(25.4 mm) and a maximum of						
	12 in. (305 mm) b	elow the ceiling						
	(4) Installed with t	he deflectors within the						
	horizontal planes	in. to 6 in. (25.4 mm to 152						
	mm) below compo	osite wood joists to a						
	maximum distance	e of 22 in. (559 mm) below the						
	ceiling/roof deck of	only where joist channels are						
	firestopped to the	full depth of the joists with						
	material equivalen	t to the web construction so						
	that individual cha	nnel areas do not exceed 300 ft						
	2 (27.9 m 2)							
	(5)*Installed with	deflectors of sprinklers under						
	concrete tee constr	ruction with stems spaced less						
	than 71.2 ft (2.3 m	) but more than 3 ft (0.91 m)						
	on centers, regardl	ess of the depth of the tee,						
	located at or above	e a horizontal plane 1 in. (25.4						
	mm) below the bo	ttom of the stems of the tees						
	and shall comply v	with Table 8.6.5.1.2.						
	Section 8.6.4.2.1 s	tates unless the requirements						
	of 8.6.4.2.2 or 8.6.	4.2.3 are met, deflectors of						
	sprinklers shall be	aligned parallel to ceilings,						
	roofs, or the inclin	e of stairs.						
	This deficient prac	tice could affect over 14						
	residents, staff and	l visitors in the 400 Hall.						
	Findings include:							
	Based on observat	ions with the Maintenance						

	R MEDICARE & MEDICAID SERVICES         IT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         OF CORRECTION       IDENTIFICATION NUMBER:         155491		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING			03/	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF			STREET A 1029 E S CONNE	DDE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
	<ul> <li>a.m. to 2:30 p.m. or the upright sprinkle attic near the south accessed from the C access door was em drywall affixed to th above. A picture w Maintenance Direct sprinkler in the 400 installed.</li> <li>This finding was re Director and the Ma the exit conference.</li> <li>3.1-19(b)</li> <li>4. Based on observating facility failed to ma construction in 1 of East Building. NFH 3.3.5.4 defines a sm ceiling free from sig lumps, or indentation and gases around the sprinkler to operate Section 8.5.4.1.1 stat sprinkler deflector at selected based on the type of construction could affect 14 resid the 400 Hall in the 14 Findings include:</li> <li>Based on observation Director during a to a.m. to 2:30 p.m. of</li> </ul>	ation and interview, the intain the canopy 3 exterior canopies in the PA 13, 2010 edition, Section tooth ceiling as a continuous gnificant irregularities, ons. The ceiling traps hot air e sprinkler and cause the at a specified temperature. Attes the distance between the and the ceiling above shall be the type of sprinkler and the a. This deficient practice dents, staff, and visitors in						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BUILDING <u>05</u> B. WING <u>03/16/</u>		e survey pleted 6/2021	
	PROVIDER OR SUPPLIE		10	REET ADDRESS, CITY, STATE, ZI )29 E 5TH STREET ONNERSVILLE, IN 47331	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	II PRE TA	PROVIDER'S PLAN OF ( FIX (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
< 0353 SS=F Bldg. 05	the nurse's station. inches of one sprin of the canopy. Ba the observations, t agreed there was a canopy outside the Hall by the nurse's 3.1-19(b) NFPA 101 Sprinkler System Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testii Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provide c) Water system Provide in REMA coverage for any automatic sprink 9.7.5, 9.7.7, 9.7.3 1. Based on record facility failed to en was performed on piping systems tha required by NFPA for the Inspection, Water-Based Fire	a - Maintenance and Testing b - Maintenance and Testing ler and standpipe systems sted, and maintained in NFPA 25, Standard for the ng, and Maintaining of e Protection Systems. m design, maintenance, esting are maintained in a and readily available. er system last checked d system test n supply source	K 0353	1. The allegation is pipe sprinkler system building needs to be Weekly inspections of sprinkler system has done. Not all spare the premises were s spare sprinkler cabir	n for the East flushed. on dry not been sprinklers on tored in the	04/19/202

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 05 COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) requires systems shall be examined for internal hall sprinkler riser room. The obstructions where conditions exist that could deflector for the ceiling mounted sprinkler near entrance to the cause obstructed piping. Section 14.3.3, states if bathroom in room 405 were an obstruction investigation indicates the painted Sprinkler heads in the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall attic 400 hall soiled linen room and above the 400 hall clean be conducted by qualified personnel. Section 14.3.1 states if the condition has not been laundry room were covered with corrected or the condition is one that could sprayed attic insulation. 2. No residents were affected but result in obstruction of piping despite any previous flushing procedures that have been had the potential to be at risk by this deficient practice. performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff 3. qualified contractors have and visitors in the East Building. submitted proposals to flush East Findings include: Bldg. system. It is anticipated the contract will be Based on review of the sprinkler system awarded to the contractor that can inspection contractor's "Sprinkler: Five Year schedule the flush no later than week of 4/12. Internal Pipe Inspection" documentation dated 01/12/21 with the Executive Director and the Contract/documentation will be Maintenance Director during record review from submitted upon award. 2:30 p.m. to 3:45 p.m. on 03/16/21, the dry pipe 4. To ensure compliance the Maintenance Director or sprinkler system for the East Building needs to be flushed. The "Inspection Results" section of Designee will be responsible to the 01/12/21 report stated "Found rust and complete the QA monitoring tool sediment buildup in the crossmain" but it did not every day for 4 weeks, weekly for state the system was impaired. Review of 4 weeks, monthly for 3 months. sprinkler flush proposals from two different Results of audit findings will be contractors dated 01/21/21, 01/28/21 and presented to the QA committee. 02/12/21 indicated none of the proposals have Software utilized by facility to been signed by the facility. Based on interview at schedule routine inspections of the time of record review, the Executive sprinkler system gauges/valves Director and the Maintenance Director stated the has been re-formatted dry sprinkler system needs to be flushed, the for weekly inspections v twice facility has not closed on any bid for the dry monthly inspections. Maint. Dept. sprinkler system flush and agreed a dry sprinkler to document accordingly. system flush has not yet been performed.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 05 COMPLETED 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) week period. Monthly wet sprinkler system gauge and valve inspections were documented by the contractor for 4 months of the most recent 12 month period by the contractor on the aforementioned four inspection reports. Based on interview at the time of record review, the Maintenance Director stated the facility inspects dry and wet sprinkler system gauges and valves monthly as documented in "Fire System Monthly Log" documentation for the most recent twelve month period. Review of "Fire System Monthly Log" documentation indicated the facility performs monthly checks for dry sprinkler system gauges and does not document weekly inspections on dry sprinkler system gauges. Based on interview at the time of record review, the Maintenance Director stated dry sprinkler system gauges are inspected by the facility monthly not weekly. Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the facility has supervised wet and dry sprinkler systems. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler systems' spare sprinklers were kept in a cabinet. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 58 of 81

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, four spare sprinklers were stored on top of the wall mounted spare sprinkler cabinet in the 100 Hall sprinkler riser room. Based on interview at the time of the observations, the Maintenance Director agreed not all spare sprinklers on the premises were stored in the spare sprinkler cabinet in the 100 Hall sprinkler riser room. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure over more than 20 of over 200 sprinkler heads in the facility which had been painted or loaded with foreign materials were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 59 of 81

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STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BU	x2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING		COM 03/	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331			CODE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETIO	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
		nd shall be installed in the (e.g., up-right, pendent, or						
	sidewall). Furtherr	nore, at 5.2.1.1.2 any						
	sprinkler that show	s signs of any of the following						
	shall be replaced:							
	(1) Leakage							
	(2) Corrosion							
	(3) Physical Damag							
	(4) Loss of fluid in element	the glass bulb heat responsive						
	(5) Loading							
		painted by the sprinkler						
	manufacturer.	F						
	In lieu of replacing	sprinklers that are loaded						
	-	nitted to clean sprinklers with						
	-	y a vacuum provided that the						
		touch the sprinkler.						
	staff and visitors in	ice could affect all residents, the East Building.						
	Findings include:							
		ons with the Maintenance						
	-	our of the facility from 10:40						
	-	n 03/16/21, sprinkler heads in						
		400 Hall Soiled Lined Room Hall Clean Laundry Room						
		sprayed on attic insulation. In						
		tor for the ceiling mounted						
		ntrance to the bathroom in						
	-	nted. Based on interview at						
		ervations, the Maintenance						
		entioned sprinkler head						
	locations had foreig painted.	gn materials on them or were						
		viewed with the Executive						
	Director and the M the exit conference	aintenance Director during						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION 05	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE		1029 E	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH STREET CONNERSVILLE, IN 47331		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY 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)	LD BE	(X5) COMPLETIC DATE
0355 SS=E Bldg. 05	facility failed to ma systems in accorda 9.7.5 requires all at shall be inspected a with NFPA 25, Sta Testing, and Maint Protection Systems 5.2.2.2 requires spr subjected to extern resting on the pipe deficient practice c staff and visitors in Findings include: Based on observati Director during a to a.m. to 2:30 p.m. o strand of light bulb sprinkler pipe in th wall of two hour fin Clean Laundry Roo on interview at the Maintenance Direct the attic was used t components. This finding was re Director and the M the exit conference 3.1-19(b) NFPA 101 Portable Fire Exti Portable Fire Exti	ons with the Maintenance bur of the facility from 10:40 n 03/16/21, a long yellow s was affixed to horizontal e 400 Hall attic near the north re wall accessed from the om attic access door. Based time of the observations, the tor agreed sprinkler piping in o support nonsystem eviewed with the Executive aintenance Director during				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 K 0355 1. The allegation is the ABC 04/19/2021 Based on observation and interview, the facility failed to ensure 1 of over 10 portable fire portable fire extinguisher located extinguishers were installed in accordance with in the 100 hall electrical room was standing on the floor and not NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 secured. states portable fire extinguishers other than 2. No residents were affected but wheeled extinguishers shall be installed using had the potential to be at risk by this deficient practice. any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the 3. The Maintenance Director bracket supplied by the extinguisher immediately secured fire manufacture. (3) In a listed bracket approved for extinguisher to the wall. such purpose. (3) In a cabinet or wall recess. 4. To ensure compliance the This deficient practice could over 10 residents, Maintenance Director or staff and visitors in the 100 Hall. Designee will be responsible to complete the QA monitoring tool Findings include: every day for 4 weeks, every week for 4 weeks and every Based on observations with the Maintenance month for 3 months. Results of audit findings will be presented to Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the ABC portable the QA committee. fire extinguisher located in the 100 Hall electrical room was freestanding on the floor and was not secured or supported. The fire extinguisher contractor had affixed a hanging tag to the extinguisher documenting the most recent annual maintenance was performed in March 2020. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was freestanding on the floor and was not mounted. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MUI A. BUII B. WIN	LDING	DNSTRUCTION 05	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	Р	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	3E	(X5) COMPLETION DATE
<0362 SS=E Bldg. 05	walls constructed resistance rating compartments, p resist the transfe nonsprinklered b underside of the ceiling. Corridor underside of ceili permitted by Coo Fixed fire window walls are in acco in sprinklered coo restrictions in are or frames. If the walls have the rating	truction of Walls barated from use areas by d with at least 1/2-hour fire . In fully sprinklered smoke artitions are only required to r of smoke. In uildings, walls extend to the floor or roof deck above the walls may terminate at the ings where specifically le. v assemblies in corridor rdance with Section 8.3, but mpartments there are no ea or fire resistance of glass a fire resistance rating, give if the walls underside of the ceiling, give in REMARKS, describing yhout the floor area.	K 03	62	<ol> <li>The allegation is that the hall corridor wall had a hole the passage of cables by ro 104 and by room 210 in 200</li> <li>No resident was affected had the potential to be at ris this deficient practice.</li> <li>The Maintenance Director immediately fire caulked all</li> <li>To ensure compliance the Maintenance Director or Designee will be responsiblic complete the QA monitoring every day for 4 week, week</li> <li>weeks, every month for 3</li> </ol>	for om ) hall. I but sk by or holes. ne e to g tool	04/19/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BUILDING <u>05</u> B. WING			(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
< 0372 SS=F Bldg. 05	Maintenance Direc aforementioned op would not resist the This finding was re Director and the M the exit conference 3.1-19(b) NFPA 101 Subdivision of Bu Barrie Subdivision of Bu Barrie Subdivision of Bu Barrie Construct 2012 EXISTING Smoke barriers s 1/2-hour fire resist Smoke barriers s terminate at an a are not required in ducted HVAC system compartments ac 19.3.7.3, 8.6.7.1(	enings in the corridor wall e passage of smoke. eviewed with the Executive laintenance Director during c. uilding Spaces - Smoke uilding Spaces - Smoke ion hall be constructed to a stance rating per 8.5. hall be permitted to trium wall. Smoke dampers n duct penetrations in fully stems where an approved is installed for smoke ljacent to the smoke barrier.			months. Results of audit findir will be presented to the QA committee.	ng	
	facility failed to er walls were protect resistance of the si 19.3.7.5 requires s constructed in acco and shall have a m rating. This defici	RKS. vation and interview, the usure 3 of 5 smoke barrier ed to maintain the fire moke barrier. LSC Section moke barriers to be ordance with LSC Section 8.5 inimum ½ hour fire resistive ent practice could affect all visitors in the East Building.	K 0.	372	<ol> <li>The allegation is that the access door in the 100 hall att was propped open. Each of th three smoke barrier wall attic access doors were affixed. Howere noted in the ceiling smok barrier above the electrical pain the 400 hall electrical room.</li> <li>No residents were affected had the potential to be at risk to this deficient practice.</li> <li>The Maintenance Director</li> </ol>	ne bles ce nel but	04/19/202

# **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 B. WING 155491 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET CONNERSVILLE, IN 47331 MAJESTIC CARE OF CONNERSVILLE (X5) COMPLETION DATE

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)
	Based on observations with the Maintenance		closed all access doors in the
	Director during a tour of the facility from 10:40		attic. All holes in ceiling smoke
	a.m. to $2:30$ p.m. on $03/16/21$ , the wall mounted		barrier above electrical panel in
	access door in the 100 Hall smoke barrier wall in		400 hall electrical room repaired
	the attic was propped open. The wall mounted		4. To ensure compliance the
	access door in the 400 Hall smoke barrier wall in		Maintenance Director or
	the attic was also propped open. The wall		Designee will be responsible to
	mounted access door in the 200 Hall smoke		complete the QA monitoring too
	barrier wall in the attic was in the fully open		every day for 4 weeks, every
	position because the spring which served as the		week for 4 weeks and every
	self closing device for the door was dangling		month for 3 months. Results of
	from the door. Each of the three smoke barrier		audit findings will be presented
	wall attic access doors was affixed with a 90		the QA committee.
	minute fire resistance rating label. Each attic		
	smoke barrier wall consisted of two layers of		
	5/8ths inch thick drywall on each side of the wall		
	studs. In addition, a two inch gap was noted		
	between the edge of the drywall and the frame		
	for the access door in the 400 Hall smoke		
	barrier wall in the attic. Two open ended		
	conduits, which were not firestopped, for the		
	passage of cables was also noted above the wall		
	mounted attic access door. Based on interview at		
	the time of the observations, the Maintenance		
	Director agreed the aforementioned openings in		
	the smoke barrier wall did not maintain the fire		
	resistance rating of the wall.		
	This finding was reviewed with the Executive		
	Director and the Maintenance Director during		
	the exit conference.		
	3.1-19(b)		
	2. Based on observation and interview, the		
	facility failed to ensure openings through 1 of 1		
	ceiling smoke barriers was protected to maintain		
	the fire resistance rating of the smoke barrier.		
	LSC 19.3.7.3 refers to Section 8.5. Section		
	8.5.6.2 states penetrations for cables, conduits,		

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 05	СОМ	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIE		STREET 1029 E CONNI	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
(0511 SS=F	pipes and similar it floor/ceiling assemi barrier, or through to ceiling smoke barri system or material transfer of smoke. also constructed as penetrations shall b with the requirement the spread of fire for fire resistance of th This deficient pract residents, staff and 400 Hall mechanica Findings include: Based on observation Director during a to a.m. to 2:30 p.m. or in the ceiling smoke panel identified as electrical room by to interview at the tim Maintenance Direct aforementioned opp barrier were not pro- resistance rating of This finding was re	ems that pass through a bly constructed as a smoke the ceiling membrane of a er shall be protected by a capable of resisting the Where a smoke barrier is a fire barrier, the e protected in accordance ths of Section 8.3.5 to limit or a time period equal to the e assembly and Section 8.5.6. ice could affect over 10 visitors in the vicinity of the al room. ons with the Maintenance pur of the facility from 10:40 n 03/16/21, holes were noted e barrier above the electrical 'ECR1 Feed" in the 400 Hall he nurse's station. Based on e of the observations, tor agreed the enings in the ceiling smoke otected to maintain the fire the ceiling smoke barrier. viewed with the Executive aintenance Director during					
Bldg. 05	Utilities - Gas and Equipment using						

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

	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETIO DATE
	complies with NFF Code. Existing ins service provided m 18.5.1.1, 19.5.1.1, Based on observation failed to ensure all of corridors were secure personnel. NFPA 7 Energized parts of s enclosed as specifie specified in 230.62( (A) Enclosed. Energy so that they will not contact or shall be g (B) Guarded. Energy enclosed shall be im panelboard, or contr accordance with 110 energized parts are g 110.27(A)(1) and (A sealing doors provid shall be provided. This deficient practi- staff and visitors in Findings include: Based on observation Director during a to a.m. to 2:30 p.m. on electrical panel in th receiving room idem mounted electrical p Room 101 were eace interview at the time Maintenance Direct aforementioned elect	9.1.1, 9.1.2 on and interview, the facility electrical panels in the red from non-authorized 0, 2011 edition states 230.62 ervice equipment shall be d in 230.62(A) or guarded as B). gized parts shall be enclosed be exposed to accidental uarded as in 230.62(B). ized parts that are not stalled on a switchboard, col board and guarded in 0.18 and 110.27. Where guarded as provided in A)(2), a means for locking or ling access to energized parts ce could affect all residents, the East Building.	К 0.	511	<ol> <li>The allegation is that the mounted electrical panel in a corridor by the 200 hall recerroom wall mounted electrication the corridor by room 101 each not locked.</li> <li>No resident was affected had potential to be at risk by deficient practice.</li> <li>The Maintenance Director immediately locked both part 4. To ensure compliance the Maintenance Director or Designee will be responsible complete the QA monitoring every day for 4 weeks, ever week for 4 weeks and every month for 3 months.</li> </ol>	the viving al panel were but y this or nels. e tool y	04/19/202

PRINTED: 04/12/2021 FORM APPROVED OMB NO 0938-0391

DEPARTMENT OF HEA	LTH AND HUMAN SERVICES	
CENTERS FOR MEDICA	RF & MEDICAID SERVICES	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MUI A. BUII B. WIN	LDING	05	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEI			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMP	(X5) PLETIO ATE
< 0911 SS=E Bldg. 05	Director and the M the exit conference 3.1-19(b) NFPA 101 Electrical System Electrical System List in the REMAR Chapter 6 Electric that are not addre K-Tags, but are d along with the app NFPA standard ci on Form CMS-25 Chapter 6 (NFPA 1. Based on observ facility failed to en safety branch suppl for life safety in ac NFPA 99, Health C Edition, Section 6.4 branch shall supply receptacles, and eq (1) Illumination of accordance with NI (2) Exit signs and c accordance with NI (3) Hospital comm	s - Other s - Other KS section any NFPA 99 cal Systems requirements assed by the provided eficient. This information, blicable Life Safety Code or tation, should be included 67. 99) ation and interview, the sure all circuits on the life y power to circuits essential cordance with NFPA 99. Care Facilities Code, 2012 4.2.2.3.2 states the life safety power for lighting, uipment as follows: means of egress in FPA 101, Life Safety Code. wit directional signs in FPA 101, Life Safety Code. unication systems, where truction during emergency cation as follows:	К 09	11	<ol> <li>The allegation is that the facility did not have the Nurse's call circuit on the critical branch circuit. Multiple items were store in front of the electrical panel.</li> <li>No residents were affected b had the potential to be at risk by this deficient practice.</li> <li>The Maintenance Director immediately removed all debris from in front of the electrical panel. Electrical company called in to place the Nurse's call circuit onto the critical branch circuit.</li> <li>To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool</li> </ol>	ut	9/202
		es at the generator set ial electrical system transfer			every day for 4 weeks, every week for 4 weeks, and every month for 3 months.		

	R MEDICARE & MEDI				NETRICTION		OMB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	~ /	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	05	- 1	IPLETED
		155491	B. W	/ING		_ 03/1	16/2021
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP C	ODE	
					5TH STREET		
MAJEST	IC CARE OF CON	INERSVILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	HOULD BE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and signaling systems.					
	(6) Electrically po	wered doors used for building					
	egress.						
		d auxiliary functions of fire					
	alarm combination	n systems complying with					
	NFPA 72, Nationa	al Fire Alarm and Signaling					
	Code.						
		states alarm and alerting					
	systems (other that	n fire alarm systems) shall be					
	connected to the li	fe safety branch or the critical					
	branch. Section 6	.4.2.2.3.4 states loads					
	dedicated to a spe	cific generator, including the					
	fuel transfer pump	(s), ventilation fans,					
	electrically operat	ed louvers, controls, cooling					
	systems, and other	generator accessories					
	essential for gener	rator operation, shall be					
	connected to the li	fe safety branch or the output					
	terminals of the ge	enerator with over-current					
	protective devices	. Section 6.4.2.2.3.5 states no					
	functions other that	an those in 6.4.2.2.3.2,					
	6.4.2.2.3.3, and 6.	4.2.2.3.4 shall be connected to					
	the life safety bran	nch, except as specifically					
	permitted in 6.4.2	2.3. Section 6.4.2.2.6.1 states					
	the life safety bran	hch shall be kept independent					
	of all other wiring	and equipment. This deficient					
	practice could affe	ect 14 residents.					
	Findings include:						
	Based on observat	ions with the Maintenance					
		lectrical contractor during a					
		from 10:40 a.m. to 2:30 p.m.					
		urse's call circuit in the wall					
		subpanel in the 100/200 Hall					
		rom the circuits in the life					
		el identified as "ELS400" in the					
		cal room. Based on interview					
		observations, the electrical					
		the nurse's call circuit should					
	-	branch circuit and not the life					
	I be on me critical t	namen eneunt and not the nit	1		1		1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	ì í	UILDING	05	COM	(X3) DATE SURVEY COMPLETED 03/16/2021	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD	E		
					5TH STREET RSVILLE, IN 47331			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	safety branch.							
	This for the second							
		eviewed with the Executive						
		Aaintenance Director during						
	the exit conference	τ.						
	3.1-19(b)							
	2. Based on obser	vation and interview, the						
		nsure access and working						
	space was maintai	ned in enclosures housing						
	-	is in 1 of over 2 mechanical						
	rooms in the East	Building. NFPA 99, Health						
	Care Facilities Co	de, 2012 Edition, Section						
	6.3.2.1 states elect	trical installation shall be in						
	accordance with N	IFPA 70, National Electric						
	Code. NFPA 70,	2011 Edition, Article 110.26						
	states working spa	ce for equipment operating at						
	600 volts, nomina	l, or less and likely to require						
	examination, adju	stment, servicing, or						
		e energized shall comply with						
		110.26(A)(1), (2) and (3).						
		measured from the live parts						
	-	xposed or from the enclosure						
		f such are enclosed. Article						
		he working space required by						
		not be used for storage. This						
		could affect over 10 residents,						
	staff and visitors i	n the East Building.						
	Findings include:							
	Based on observat	tions with the Maintenance						
	Director during a	tour of the facility from 10:40						
	a.m. to 2:30 p.m.	on 03/16/21, two 44 gallon						
	trash carts, a foldi	ng chair, a portable cart and						
	window blinds in	cardboard boxes were all stored						
	within three feet o	f the three electrical panels						
	identified as Panel	A, Panel B and Panel C in the						
	100 Hall mechanic	cal room. Based on interview						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE. IN 47331 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of or under the electrical panels at the aforementioned location. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) K 0918 **NFPA 101** SS=F Electrical Systems - Essential Electric Syste Bldg. 05 **Electrical Systems - Essential Electric** System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records VZOT21 Facility ID: 000316

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

Event ID:

If continuation sheet

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STATEMENT O	OF DEFICIENCIES CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE C A. BUILDING B. WING	005	X3) DATE SURVEY COMPLETED 03/16/2021
	OVIDER OR SUPPLIE		1029 E	ADDRESS, CITY, STATE, ZIP CODE 55TH STREET ERSVILLE, IN 47331	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIO
a a a b b c c c c c c c c c c c c c c c	of maintenance a and readily availa and circuits are n and separate from Minimizing the po- emergency power consideration for 5.4.4, 6.5.4, 6.6.4 NFPA 111, 700.1 1. Based on record facility failed to ex- 12 months to meet 10, 2010 Edition, and Standby Power Section 8.4.2 state service shall be ex- for a minimum of following methods (1) Loading that m gas temperatures a nanufacturer 2) Under operatin at not less than 30 Emergency Power Section 8.4.2.3 sta nstallations that d	I review and interview, the tercise the generator for 1 of the requirements of NFPA the Standard for Emergency rs Systems, Chapter 8.4.2. s diesel generator sets in ercised at least once monthly, 30 minutes, using one of the	тад К 0918	<ol> <li>The allegation is that on 1-29-21 a monthly load test for diesel powered generator was documented. No battery powe emergency lighting was attache to the outside building near the 400 hall dining room.</li> <li>No resident was affected, resident had potential to be at the by this deficient practice.</li> <li>The Maintenance Director has corrected the load test for the generator. Battery powered emergency lighting has been attached to the inside of the building attached to the 400 has dining room. This was installed 4/8/21</li> </ol>	the not red ed since and the not red ed since and the not red ed since and the not not red ed since and the not
a S S T T I I f f C C a I	available EPSS (E System) load and s supplemental load the EPS nameplate ninutes and at not EPS nameplate kW for a total test dura continuous hours. affect all residents Findings include:	f "Emergency Power		4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring to every day for 4 weeks, every week for 4 weeks and monthly 3 months.	ol

	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING <u>05</u> 155491 B. WING		INSTRUCTION 05	(X3) DATE SURVEY COMPLETED 03/16/2021	
	PROVIDER OR SUPPLIEF		1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET	
MAJES		IERSVILLE	CONNE	RSVILLE, IN 47331	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	e (X5) COMPLETIC DATE
	Executive Director Director during rec 3:45 p.m. on 03/16, percentage achieved monthly load test for generator was not d interview at the tim Maintenance Direct the load percent for agreed the January percent achieved w This finding was re Director and the Ma the exit conference. 3.1-19(b) 2. Based on observa facility failed to en- generator battery ba 1 of 1 automatic tra 110, 2010 Edition a Level 1 or Level 2 shall be provided w emergency lighting apply to units locat do not include walk (1) requires functio monthly, with a mir maximum of 5 wee than 30 seconds, (3 conducted annually hours if the emerge powered and (5) W inspections and test for inspection by th	d 01/29/21 with the and the Maintenance ord review from 2:30 p.m. to 21, the actual load d for the January 2021 or the diesel powered ocumented. Based on e of record review, the for stated he normally records monthly load testing but 2021 monthly load test as not documented. viewed with the Executive aintenance Director during attion and interview, the sure 1 of 1 emergency task ackup lighting was installed in nsfer switch rooms. NFPA t section 7.3.1 requires the EPS equipment location(s) ith battery-powered . This requirement shall not ed outdoors in enclosures that t-in access. Section 7.9.3.1.1 nal testing shall be conducted nimum of 3 weeks and a ks between tests, for not less ) Functional testing shall be for a minimum of 1 1/2 ncy lighting system is battery ritten records of visual s shall be kept by the owner			

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. 1	BUILDING WING	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF			1029 E	ADRESS, CITY, STATE, ZIP CO 5TH STREET RSVILLE, IN 47331	ODE	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH		COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
	all residents, staff a	nd visitors in the facility.					
	Findings include:						
	Director during a to a.m. to 2:30 p.m. or constructed automa which is attached to near the 400 Hall D provided with batter lighting. Based on observations, the M the room was newly renovation to accorr and agreed the new transfer switch room battery-powered en This finding was re	viewed with the Executive aintenance Director during					
0923	NFPA 101						
0923 SS=E		Cylinder and Container					
3ldg. 05	Storag	-,					
-	Gas Equipment -	Cylinder and Container					
	Storage						
		qual to 3,000 cubic feet					
	-	are designed, constructed,					
		accordance with 5.1.3.3.2					
	and 5.1.3.3.3. >300 but <3,000 d	subic foot					
		are outdoors in an					
	-	n an enclosed interior					
		imited- combustible					
		door (or gates outdoors)					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	ì í	ILDING NG	onstruction <u>05</u>	(X3) DATE COMPI 03/16	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
MAJEST	IC CARE OF CON	NERSVILLE			5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	)N	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	from combustible sprinklered) or er noncombustible of minimum 1/2 hr. Less than or equ In a single smoke cylinders availab patient care area of less than or eo not required to be Cylinders must b as specified in 11 A precautionary s on each door or g room, where the a minimum "CAU STORED WITHII Storage is planne order of which the supplier. Empty from full cylinders cylinders with inte threshold pressu established. Em avoid confusion. are protected fron 11.3.1, 11.3.2, 17 99) 1. Based on observinterview; the facil oxygen transfilling ventilation. NFPA for the purposes of fluid (gas and liqui the ventilation requ of the stored fluid temperature and pus- single vessel in the	sign readable from 5 feet is gate of a cylinder storage sign includes the wording as ITION: OXIDIZING GAS(ES) N NO SMOKING." ed so cylinders are used in ey are received from the cylinders are segregated s. When facility employs egral pressure gauge, a re considered empty is pty cylinders are marked to Cylinders stored in the open	K 09	923	1. The allegation is that the facility neglected to post a sindicating smoking is not permitted. Wall mounted el outlet box for two receptacl installed 12 inches above th and second wall mounted electrical outlet box was ins 46 inches above floor in the hall oxygen storage room a were not protected.	sign ectrical es was he floor stalled e 400	04/19/202

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	05	COMPL	ETED
		155491	B. WING			03/16/	2021
			ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			5TH STREET		
	IC CARE OF CON				RSVILLE, IN 47331		
(X4) ID		STATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ſE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		1 L/sec of airflow for each			2. No residents were affected		
	· •	ft3 of fluid) designed to be			residents had the potential to b	be at	
	-	and not less than 24 L/sec (50			risk by this deficient practice.		
		1 235 L/sec (500 cfm). This			3. See exhibit R. Submitted		
	_	vill affect all vent unit			documents final agreed cylind		
	residents.				quantities and sizes with ISDH		
					Reviewer Jon Clifford for oxyg	en	
	Findings include:				storage room HVAC upgrade	-1	
					design, subsequently approve	a,	
		f the facility's proposed			implemented and completed.		
		roved by the Indiana			Residents will primarily use		
	*	lth (IDOH) with the Plan			oxygen concentrators located	in	
	-	nt Supervisor and lead reviewer			each resident room. Oxygen	`	
		12:15 p.m. to 12:30 p.m., the			storage room tanks (e-cylinder	s)	
	-	85 CFM exhaust fan. Based			are primarily used for resident		
		ed by the Lead Reviewer on			mobility requirements (leaving		
	-	p.m., the largest vessel in the			resident room). Signage was		
		om will be 250 cubic feet.			purchased and placed		
		ons with the Maintenance			accordingly.	<b>f</b> 4	
	-	our of the facility from $10:40$			425 oxy storage room is 64 sq		
	-	n 03/16/21, the oxygen			(4) h cylinders racked requires		
	-	equipped with a mechanical ed on an interview with the			min. 4 sq. ft. (28) e cylinders		
		tor at the time of the			racked requires min. 7 sq. ft. (verticle), racked		
		xygen storage room on the			horizontal can be less than 7.		
		ed for transfilling of small			Need total 11 sq. ft to store rad	rked	
		a large stationary liquid			cylinders (less if e cylinders		
	•	each containing 1,235 (STP)			are racked wall mounted.) Fac	ility	
		oxygen. Based on an			will replenish storage as neede	-	
	-	Maintenance Director at the			based on consumption/deman		
		ations, he was concerned the			cylinders for		
		om would not be large enough			mobility purposes. Ox		
		liquid oxygen needed for 14			concentrators primary vent		
	vent residents.	1			source. Largest cylinder in roo	m	
					(h) is 250 ft3, 1 cfm per 5 ft3		
	3.1-19(b)				required exhaust. 250/5=50cfr	n	
					required. Room balanced at 8		
	2. Based on observ	ration and interview, the			cfm (more than required)	-	
		sure 1 of 1 storage locations			Monitoring procedure ensure F	PoC	
		ases was marked with a			is effective and that cited	-	

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Event ID: VZOT21 Facility ID: 000316

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	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(¥2) )		ONSTRUCTION		MB NO. 0938-03 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER: 155491	A. E	UILDING	<u>05</u>	СОМ	COMPLETED 03/16/2021	
NAME OF	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP CODE			
	IC CARE OF CON				5TH STREET ERSVILLE, IN 47331			
(X4) ID		STATEMENT OF DEFICIENCIES					(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	ION D BE	COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE	
	precautionary sign	which includes the wording as			deficiency remains correct	ed / in		
		TION: OXIDIZING GAS(ES)			compliance:			
	STORED WITHIN	N NO SMOKING." This			Passive and scheduled Ma	aint.		
	deficient practice	could affect over 10 residents,			Dept inspections for prope	r		
		n the vicinity of the oxygen			operation.			
	storage and transfilling room in the 400 Hall.				4. To ensure compliance	the		
	T. 1				Maintenance Director or	hla t-		
	Findings include:				Designee will be responsi			
	Based on observat	ions with the Maintenance			complete the QA monitorin daily for 4 weeks, weekly f	-		
		tour of the facility from 10:40			weeks and monthly for 3 n			
		on $03/16/21$ , the oxygen			Passive and scheduled Ma			
	-	lling room in the 400 Hall was			Dept inspections for prope			
	not posted with signs indicating smoking in the immediate area is not permitted. Based on interview at the time of the observations, the Maintenance Director stated the facility is a				operation.			
		oxygen storage and transfilling						
		bom and agreed the area was						
	permitted.	sign indicating smoking is not						
		eviewed with the Executive						
	the exit conference	faintenance Director during e.						
	3.1-19(b)							
	3. Based on observ	vation and interview, the						
		nsure wall mounted electrical						
	fixtures in 1 of 1 of	xygen storage and transfilling						
	-	ted. NFPA 99 Health Care						
		012 Edition, Section 5.1.3.3.2						
		10) both requires locations for						
		tems and the storage of						
		gases to protect electrical						
		ical damage. A.5.1.3.3.2 (5) vices should be physically						
		by use of a protective barrier						
	-	al devices, or by location of					1	

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 05 155491 B. WING 03/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 E 5TH STREET MAJESTIC CARE OF CONNERSVILLE CONNERSVILLE, IN 47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) the electrical device such that it will avoid causing physical damage to the cylinders or containers. For example, the device could be located at or above 5 feet above finished floor or other location that will not allow the possibility of the cylinders or containers to come into contact with the electrical device as required by this section. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room in the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, a wall mounted electrical outlet box for two receptacles was installed twelve inches above the floor and a second wall mounted electrical outlet box was installed 46 inches above the floor in the 400 Hall oxygen storage and transfilling room and were not protected. The wall mounted light switch for the room was also mounted less than 5 feet above the floor and was also not protected. The measurements were taken with a measuring tape. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned wall mounted electrical were not protected by a protective barrier and were less than 5 feet above the floor. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) K 0927 **NFPA 101** SS=E Gas Equipment - Transfilling Cylinders FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VZOT21 Facility ID: 000316 If continuation sheet Page 78 of 81

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	r í	ILDING	05	(X3) DATE S COMPLE 03/16/2	TED
	PROVIDER OR SUPPLIEF			1029 E	address, city, state, zip code 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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
Bldg. 05	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen c containers over 50 conditions under Transfilling to liqu portable container conditions under 11.5.2.2 (NFPA 99 Based on observation failed to ensure 1 or locations was provi- transferring is occu Facilities Code, 201 11.5.2.3.1(3) states, indicating that trans- smoking is the imme- This deficient pract residents, staff and oxygen storage and Hall. Findings include: Based on observation Director during a to a.m. to 2:30 p.m. or storage and transfill with a sign indication occurs in this locati- immediate area is n interview at the time Maintenance Direct smoking facility, or	Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, in Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable 0 psi comply with 11.5.2.3.1 (NFPA 99). id oxygen containers or to is under 50 psi comply with 11.5.2.3.2 (NFPA 99). 9) on and interview, the facility f 1 oxygen storage/transfer ded with a sign indicating that trring. NFPA 99 Health Care 12 Edition, Section the area is posted with signs stilling is occurring and that ediate area is not permitted. ice could affect over 10 visitors in the vicinity of the transfilling room in the 400	K 09		<ol> <li>The allegation is that the facility failed to have signage outside of the oxygen storage transfilling room. And that smoking in the immediate area not permitted.</li> <li>No residents were affected had the potential to be at risk to this deficient practice.</li> <li>The Maintenance Director immediately ordered the signa and it was placed.</li> <li>To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring to daily for 4 weeks, then weekly 4 weeks and monthly for 3 months.</li> </ol>	and a is but by ge ool for	04/19/202 e 79 of 81

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING <u>05</u> B. WING		COMPL	
		155491	B. W.	NG		03/16/	2021
	PROVIDER OR SUPPLIEI			1029 E	ADDRESS, CITY, STATE, ZIP CODE 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	with the necessary	,					
	-	viewed with the Executive aintenance Director during					
K 9999							
Bldg. 05	State 5' 1'						04/10/202
	State Findings		K 9	999	1. The allegation is that the facility failed to have each		04/19/202
	3.1-19 ENVIRONN STANDARDS	MENT AND PHYSICAL			sleeping room on 100 hall, 200		
	STANDARDS				hall and 400 hall equipped window smoke alarm.	iin a	
	constructed, equipp	ity must be designed, bed and maintained to protect y of residents, personnel, and			<ol> <li>No resident was affected residents had the potential to risk by the deficient practice.</li> <li>The Maintenance Director immediately placed battery</li> </ol>	be at	
	by:	not been met as evidenced			operated smoke detectors in resident room.		
	failed to provide sn	on and interview, the facility noke detectors in all resident he renovated 100 Hall, 200			4. To ensure compliance the Maintenance Director or Designee will be responsible		
	Hall and 400 Hall i	n the East Building. This ould affect all residents in the			complete the QA monitoring daily Monday - Friday for 4		
	East Building.	ourd arrest an residents in the			weeks, weekly for 4 weeks, a monthly for 3 months.	Ind	
	Findings include:				monuny for 5 monuts.		
	Director during a to a.m. to 2:30 p.m. or sleeping rooms in t Hall and 400 Hall i equipped with a sm	ons with the Maintenance our of the facility from 10:40 n 03/16/21, all resident he renovated 100 Hall, 200 n the east building were not toke detector. Based on					
		e of the observations, the tor stated each room had been					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039									
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING <u>05</u>			COMPLETED			
155491			B. WIN	B. WING			/2021		
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE 5TH STREET	-			
MAJESTIC CARE OF CONNERSVILLE				CONNERSVILLE, IN 47331					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE		
	equipped with a smo	oke detector but they were							
	removed to paint the	e rooms and were not							
	reinstalled and agre	ed each resident sleeping							
	room in the renovated portions of the East								
	Building were not equipped with a smoke								
	detector.								
	This finding was rev	viewed with the Executive							
	e	aintenance Director during							
	the exit conference.	e e							
	3.1-19(a)								
	× ′								
•	•		•						

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