DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 09			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/12/2023	
	PROVIDER OR SUPPLIE			701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	•	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE GCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON D BE OPRIATE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	conducted by the Ir accordance with 42  Survey Date: 06/12  Facility Number: 0 Provider Number: AIM Number: 200  At this Emergency Care of North Vern compliance with En Requirements for N Participating Provid 483.73.  The facility has 120 the survey, the censure of North Vern compliance with En Requirements for N Participating Provid 483.73.  The facility has 120 the survey, the censure of North Vern compliance with En Requirements for N Participating Provid 483.73.  The facility has 120 the survey, the censure of North Air Survey, the censure of North Air Survey of North Air Sur	2/23 2/10996 155665 232210  Preparedness survey, Majestic ton was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR  O certified beds. At the time of sus was 110.  42 CFR, Subpart 483.73 is NOT by:  Inducted on 06/13/23  (e), 485.625(e)  I LTC Emergency Power tion for Participation: Indicated standby power systems. It implement emergency and stems based on the set forth in paragraph (a) of the policies and set forth in paragraphs (b)(1) section.	E 0	000	The creation and submiss this Plan of Correction do constitute an admission I provider of any conclusion forth in the statement of deficiencies, or any violat regulation.  This provider respectfully requests that State Report of Correction be considered. Letter of Credible Allegated. This provider alleges compliance as of 06/26/20. The facility respectfully requests a desk review for Plan of Correction relative the low scope and severithis survey in lieu of a post-survey revisit.	pes not by this on set tion of rt Plan red the ion.	

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

TITLE (X6) DATE

Phil Ford Executive Director 06/21/2023

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

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

PRINTED: 06/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BUIL B. WINC		<del></del>	06/12/2023	
		100000				00/12/2	UZJ
NAME OF P	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF NORT	TH VERNON			NRY STREET VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<del>                                     </del>	ID	DROWIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	ΓAG	DEFICIENCY)		DATE
	` '	d standby power systems.					
		and the CAH] must					
		ency and standby power the emergency plan set					
	l -	(a) of this section.					
	. , , , .	83.73(e)(1), §485.625(e)(1)					
		ator location. The					
	•	e located in accordance with rements found in the Health					
		de (NFPA 99 and Tentative					
		nts TIA 12-2, TIA 12-3, TIA					
		nd TIA 12-6), Life Safety					
	Code (NFPA 101	and Tentative Interim					
		12-1, TIA 12-2, TIA 12-3,					
		d NFPA 110, when a new					
	structure is built of	_					
	structure or buildir	ng is renovated.					
	482.15(e)(2), §483	3.73(e)(2), §485.625(e)(2)					
	. , , , -	ator inspection and testing.					
	The [hospital, CAl	H and LTC facility] must					
	1	ergency power system					
		, and [maintenance]					
	I -	nd in the Health Care					
	Code.	FPA 110, and Life Safety					
	Jouc.						
	482.15(e)(3), §483	3.73(e)(3), §485.625(e)(3)					
		ator fuel. [Hospitals, CAHs					
	_	that maintain an onsite fuel					
		mergency generators must					
	1	w it will keep emergency					
	power systems op emergency, unles	perational during the					
	emergency, unles	s it evacuales.					
		§482.15(h), LTC at					
	- '-'	AHs §485.625(g):]					
		orporated by reference in					
	this section are ap	proved for incorporation by					

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Event ID:

2X7521

Facility ID: 010996

If continuation sheet

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155665	B. W.	JILDING ING	<del></del>	1	LETED 2/2023
		10000				00/12	,, 2020
NAME OF	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	TIC CARE OF NORT	TH VERNON			I VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY OF T		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	Director of the Office of the					
		n accordance with 5 U.S.C.					
	1 '	R part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
	, ,	mation on the availability of					
	this material at NARA, call 202-741-6030, or						
	go to: http://www.archives.gov/federal_register/code						
	_of_federal_regulations/ibr_locations.html.						
	1	this edition of the Code are					
		eference, CMS will publish a					
	1 '	ederal Register to					
	announce the cha	<u> </u>					
		Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 02169						
	1.617.770.3000.	o, mmpa.o.g,					
		th Care Facilities Code,					
	'	ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued	` ,					
		FPA 99, issued August 9,					
	2012.						
		FPA 99, issued March 7,					
	2013.						
	(v) TIA 12-5 to NF	FPA 99, issued August 1,					
	2013.	-					
	(vi) TIA 12-6 to NI	FPA 99, issued March 3,					
	2014.						
		fe Safety Code, 2012					
	edition, issued Au	~					
	` '	IFPA 101, issued August					
	11, 2011.						
	(ix) TIA 12-2 to NI	FPA 101, issued October					
	30, 2012.						

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(x) TIA 12-3 to NFPA 101, issued October

Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 06/12/2023 155665 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009... Based on observation and interview, the facility E 0041 K041-F 06/26/2023 failed to implement the emergency power system What corrective action(s) will be inspection, testing and maintenance requirements accomplished for those residents found in the Health Care Facilities Code, NFPA found to have been affected by the 110, and Life Safety Code in accordance with 42 deficient practice? CFR 483.73(e)(2). This deficient practice could The 3-position switch has affect all residents, staff and visitors. been cleaned and is operating as it should following this service. Findings include: A new 3-position switch has been ordered and will be installed Based on observations with the Maintenance when received. Director during the initial walk through of the facility at 9:45 a.m. on 06/12/23, the "overcrank" How other residents having the status indicator light for the wall mounted remote potential to be affected by the annunciator panel located at the C Hall nurse's same practice will be identified station was illuminated in red indicating system and what corrective action(s) will trouble. The Maintenance Director tried to reset be taken? the annunciator panel indicator light by pushing the reset button on the panel but the status All Residents residing in the indicator light remained illuminated in red. The facility could be affected. facility's diesel fired emergency generator located outside the facility on the south side of the What measures will be put into grounds was not in operation. Based on interview place and what systemic changes at the time of the observations, the Maintenance will be made to ensure that the Director stated he was not aware of any generator deficient practice does not recur? issues and stated the emergency generator would start if the building were to lose power but agreed Inspection of the the "overcrank" status indicator light for the wall Annunciator Panel has been

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mounted remote annunciator panel was

illuminated. Based on observations with the

from 1:00 p.m. to 3:20 p.m. on 06/12/23, the

"overcrank" status indicator light remained

Maintenance Director during a tour of the facility

Event ID:

2X7521

Facility ID: 010996

schedule.

added to the Maintenance

Supervisor's ongoing inspection

his designee, will be performed to

Ongoing review by the ED, or

If continuation sheet

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

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BU B. W.	JILDING ING	<del></del>	COMPLE 06/12/2	
		100000	B. W.			00/12/2	:UZ3
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MA IESTI	IC CARE OF NORT	'H VERNON	701 HENRY STREET NORTH VERNON, IN 47265				
IVIAJEOTI	O CARE OF NORT	II VERINON					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	illuminated.	LSC IDENTIFYING INFORMATION	+	TAG	ensure scheduled inspections	oro	DATE
	mummated.				being completed and followed		
	These findings were	e reviewed with the Executive		on as planned.		ир	
	_	aintenance Director during the			on do plannou.		
	exit conference.	5			How the corrective action(s) w	vill be	
					monitored to ensure the deficie		
					practice will not recur, i.e., who	at	
					quality assurance program wil	l be	
					put into place?		
					For Quality Assurance, t	he	
					Maintenance Supervisor, or hi		
					designee, will review the		
					Annunciator Panel 5 days a w	eek	
					for 2 weeks, then weekly for 6		
					weeks, then monthly for an		
					additional 4 months.		
					2. Findings will be reported		
					the ED and the QA Committee 6 months and will continue un		
					100% compliance has been	ui	
					achieved.		
K 0000							
1. 0000							
Bldg. 01		D. Jan J. Jan					
		Recertification and State	K 0	000	The creation and submission		
	•	ras conducted by the Indiana			this Plan of Correction does		
	483.90(a).	th in accordance with 42 CFR			constitute an admission by to provider of any conclusion s		
	703.70(a).				forth in the statement of	- L	
	Survey Date: 06/12	2/23			deficiencies, or any violation	of	
	, <i></i>				regulation.		
	Facility Number: 0	10996			This provider respectfully		
	Provider Number:	155665			requests that State Report Pl	lan	
	AIM Number: 2002	232210			of Correction be considered	the	
					Letter of Credible Allegation.	.	
	_	Code survey, Majestic Care Of			This provider alleges		
		ound not in compliance with			compliance as of 06/26/2023.		
	Requirements for Pa	articipation in			The facility respectfully		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/12/2023	
	ROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protec Life Safety Code (L	, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, sSC), Chapter 19, Existing ancies and 410 IAC 16.2.		requests a desk review for the Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.	
	Type V (111) construction The facility has a find detection in the corrections, and hard resident sleeping rorooms were surveyed.	ity was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the wired smoke detectors in all oms. All 61 resident sleeping red. The facility has a capacity nsus of 110 at the time of this			
K 0211 SS=E Bldg. 01	in accordance with of egress is continuously mainta	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility 7 means of egress was ained free of all obstructions	K 0211	K211-E What corrective action(s) will accomplished for those reside	
	fire or other emerge	full instant use in the case of ency. This deficient practice residents, staff and visitors if facility.		found to have been affected be deficient practice?  1. The drain line, electrical cord and the dehumidifier unit	

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Event ID:

2X7521

Facility ID: 010996

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/12/2023		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORT			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Findings include:  Based on observation Director during a to to 3:20 p.m. on 06/1 dehumidifiers were the corridor outside Each dehumidifier vacorridor wall oppose dehumidifier extend Based on interview observations, the M sprinkler pipe in the outside Room B107 Friday. The leak habut the dehumidifier corridor ceiling outs Maintenance Direct outside the rooms is the aforementioned continually maintain impediments to full or other emergency.	ons with the Maintenance ur of the facility from 1:00 p.m. 12/23, two separate in operation and were stored in Room B107 and Room B108. was stored up against the ite one another and each led 20 inches into the corridor. at the time of the aintenance Director stated a eattic above the corridor. In had a water leak this past and been temporarily repaired res were needed to dry out the side the rooms. The or stated the corridor width a eight feet wide and agreed means of egress was not need free of all obstructions or instant use in the case of fire		TAG	have been removed from the building.  How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) who be taken?  All Residents residing in the facility could be affected.  What measures will be put into place and what systemic channel will be made to ensure that the deficient practice does not reconstructed Hallways for progress has been added to the Maintenance Supervisor's ong inspection schedule.  2. Ongoing review by the Elhis designee, will be performe ensure scheduled inspections being completed and followed on as planned.  How the corrective action(s) we monitored to ensure the deficipractice will not recur, i.e., who quality assurance program will put into place?  1. For Quality Assurance, to Maintenance Supervisor, or his designee, will review the Unobstructed Hallways for progress 5 days a week for 2	e d will o ges e cur? pper going D, or d to are up ill be ent at I be	DATE

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

PRINTED: 06/28/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/12/2023	
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	REGULATORY OF	CESC IDENTIFY TING INFORMATION	TAG	weeks, then weekly for 6 week then monthly for an additional months.  2. Findings will be reported the ED and the QA Committee 6 months and will continue un 100% compliance has been achieved.	4 to e for	DAIL	
K 0324 SS=D Bldg. 01	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord: 19.3.2.5.2 * cooking facilities smoke compartments comply whose to the cooking facilities with 30 or fewer phatients comply whose tooking facilities with 30 or fewer phatients comply whose tooking facilities with 30 or fewer phatients conditions under a cooking facilities with 30 or fewer phatients conditions under a cooking facilities and the cooking facilities of the cooking facilities are cooking facilities and the cooking facilities are cooking facilities are cooking facilities and the cooking facilities are cooking facilities are cooking facilities and the cooking facilities are cooking facilities and the cooking facilities are cooking facilities are cooking facilities. The cooking facilities are cooking facilities are cooking facilities are cooking facilities are cooking facilities. The cooking facilities are cooking facilities are cooking facilities are cooking facilities. The cooking facilities are cooking facilities are cooking facilities are cooking facilities.	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small is microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2,  open to the corridor in ents with 30 or fewer ith the conditions under .5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor.	K 0324	K324-D		06/26/2023	
	interview; the facili kitchen exhaust sys semiannually. NFP	ty failed to ensure 1 of 1	K 0324	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice?	nts	06/26/2023	

Commercial Cooking Operations, Section 11.4

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155665	B. W	ING		06/12	/2023
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			ENRY STREET		
MAJEST	IC CARE OF NOR	TH VERNON			I VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		naust system shall be			The Range Hood Cleaning		
		e buildup by a properly			documentation shows a recor	d of	
		and certified person(s)			the past completed cleanings		
	_	uthority having jurisdiction			indicating this Range Hood w		
	_	with Table 11.4. Table 11.4,			also cleaned on 3/2/2023.	uo	
		ction for Grease Buildup,			a.55 5/54/104 5/1 6/2/2020.		
	_	rving moderate volume			How other residents having the	ne	
	cooking operations	_			potential to be affected by the		
		-			same practice will be identifie		
	semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be				and what corrective action(s)		
	contaminated with deposits from grease laden				be taken?	VVIII	
	vapors, the contaminated portions of the exhaust				be taken!		
	system shall be cleaned by a properly trained,				All Residents residing in the		
		fied person(s) acceptable to the			facility could be affected.		
	_	risdiction. Hoods, grease			lacility could be affected.		
		ans, ducts, and other			What measures will be put int		
		l be cleaned to remove			place and what systemic chai		
		ninants prior to surfaces			will be made to ensure that the	-	
		contaminated with grease or					
		he exhaust system is cleaned, it			deficient practice does not rec	our :	
		with powder or other			Inspection of the Range		
		n exhaust cleaning service is			Inspection of the Range     Hood Cleaning documentatio		
		howing the name of the			_		
		, the name of the person			been added to the Maintenan		
		k, and the date of inspection or			Supervisor's ongoing inspecti	OH	
	`	aintained on the premises.			schedule.	D or	
		tice could affect over two staff			2. Ongoing review by the E		
	in the kitchen.	lice could affect over two staff			his designee, will be performe		
	in the kitchen.				ensure scheduled inspections		
	Eindings in sluder				being completed and followed	ı up	
	Findings include:				on as planned.		
	Based on review of	the kitchen range hood					
		or's "Invoice" documentation			How the corrective action(s) v	vill be	
	-	h the Maintenance Director			monitored to ensure the defic		
		w from 9:50 a.m. to 12:40 p.m.			practice will not recur, i.e., wh		
		nentation of a semiannual			quality assurance program wi		
		stem inspection six months			put into place?	50	
		as not available for review.			pat into piaco:		

Based on interview at the time of record review,

the Maintenance Director agreed documentation

For Quality Assurance, the

Maintenance Supervisor, or his

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155665	B. W	NG _		06/12/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				NRY STREET		
MAJESTI	IC CARE OF NORT	H VERNON		NORTH VERNON, IN 47265			
1			1				(77.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		chen exhaust system		TAG	designee, will review the Rang	10	DATE
		hs prior to 06/08/23 was not			Hood Cleaning documentation		
	_	Based on observations with			days a week for 2 weeks, then		
	the Maintenance Director during a tour of the				weekly for 6 weeks, then mont		
		.m. to 3:20 p.m. on 06/12/23, the			for an additional 4 months.	ıııy	
		inspection contractor had			2. Findings will be reported	to	
	_	n sticker to the range hood			the ED and the QA Committee		
	-	ed the most recent inspection			6 months and will continue unt		
	on 06/08/23.	at the most recent inspection			100% compliance has been	.11	
	on 00/00/25.				achieved.		
	These findings were	e reviewed with the Executive			domoved.		
	Director and the Maintenance Director during the						
exit conference.							
	exit comercies.						
	3.1-19(b)						
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance	•					
	Fire Alarm System	n - Testing and					
	Maintenance						
	A fire alarm syster	n is tested and maintained					
		n an approved program					
	complying with the	e requirements of NFPA 70,					
		Code, and NFPA 72,					
		n and Signaling Code.					
		n acceptance, maintenance					
	and testing are rea	-					
	9.6.1.3, 9.6.1.5, N	-					
		review and interview, the	K 0	345	K345-F		06/26/2023
	•	oure 1 of 1 fire alarm system			What corrective action(s) will b		
		ccordance with LSC 9.6.1.3.			accomplished for those reside		
	-	s a fire alarm system to be			found to have been affected by	y the	
		d maintained in accordance			deficient practice?	_	
	· · · · · · · · · · · · · · · · · · ·	ional Electrical Code and NFPA larm Code. NFPA 72, Section			Repair documentation fo  Appuraister failure has been	ſ	
					Annunciator failure has been	iod	
	_	that system defects and be corrected. NFPA 72,			acquired confirming the identif		
		tates the requirements of			repairs needed during the forn		
		-			inspection have been complete		
	Section 10.19 shall	be applicable when a system is			<ol><li>Repair documentation for</li></ol>		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155665	B. W	NG		06/12/	/2023
				_			
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	H VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	impaired. NFPA 72	2, Section 10.19.2 states a record		Smoke Detector failures has been		een	
	shall be maintained	by the system owner or their			acquired confirming the identif	ied	
	designated representative for a period of 1-year				repairs needed during the form		
	from the date the impairment is corrected. This				inspection have been complet		
	deficient practice could affect all residents, staff				3. The Fire Panel Internal		
	and visitors.				Clocks have been adjusted so	)	
					they show the correct time.		
	Findings include:				,		
					How other residents having th	е	
	Based on review of the fire alarm system				potential to be affected by the		
	inspection contractor's "Fire Alarm Inspection"				same practice will be identified	t	
	documentation dated 08/08/22 with the				and what corrective action(s)	will	
	Maintenance Director during record review from				be taken?		
	9:50 a.m. to 12:40 p.m. on 06/12/23, the remote						
	annunciator for the facility's fire alarm system				All Residents residing in the		
	failed testing. The	"Remarks/Comments" section			facility could be affected.		
	of the 08/08/22 insp	pection report stated					
	"Annunciator Faile	d". Repair or replace			What measures will be put into	)	
	documentation for t	the fire alarm system			place and what systemic chan	ges	
	annunciator was no	t available for review. Review			will be made to ensure that the	Э	
	of the "Remarks/Co	omments" section of the fire			deficient practice does not rec	ur?	
	alarm system inspe	ction contractor's "Fire Alarm					
	Inspection" docume	entation dated 11/25/22 stated			1. Inspection of the Repair		
	"Annunciator failed	l last inspection". Based on			Documentation has been adde	ed to	
	interview at the tim	e of record review, the			the Maintenance Supervisor's		
	Maintenance Direct	tor stated the annunciator			ongoing inspection schedule.		
	passed subsequent	functional testing conducted			2. Ongoing review by the El	D, or	
	on 02/14/23 and 05	/16/23 but agreed repair or			his designee, will be performe	d to	
	replacement docum	nentation for the annunciator			ensure scheduled inspections		
	on or after 08/08/22	2 was not available for review at			being completed and followed	up	
	the time of the surv	rey.			on as planned.		
	Those findings	a varianced with the Eve			Llow the competitive	- ما الن	
	_	e reviewed with the Executive			How the corrective action(s) w		
		rector of Maintenance during			monitored to ensure the defici		
	the exit conference.	•			practice will not recur, i.e., who		
	2.1.10/1->				quality assurance program wil	ı pe	
	3.1-19(b)				put into place?		
	2 Rasad on manad	review and interview, the			1 For Quality Assurance +	ho	
		sure 1 of 1 fire alarm systems			For Quality Assurance, t     Maintenance Supervisor, or hi		
	i acinty famed to em	sure i or i inc alarm systems	1		i iviailitelialite Subelvisti. Ol []	3	1

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155665	B. W	ING		06/12/	/2023
		<u>I</u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			NRY STREET		
MAILST	IC CARE OF NORT	TH VERNON			I VERNON, IN 47265		
IVIAJEST	O CARE OF NOR	TI VERNON		NORTH	1 VERNON, IN 4/200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	was maintained in a	accordance with 9.6.1.3. LSC			designee, will review the Repa	air	
	9.6.1.3 requires a fire alarm system to be installed,				Documentation 5 days a week	( for	
	tested, and maintained in accordance with NFPA				2 weeks, then weekly for 6 we	eks,	
	·	ical Code and NFPA 72,			then monthly for an additional	4	
		n Code. NFPA 72, 2010 Edition,			months.		
		ires testing shall be performed			2. Findings will be reported		
		Table 14.4.5 Testing			the ED and the QA Committee		
	_	on 14.4.5.3.1 states sensitivity			6 months and will continue un	til	
		thin 1 year after installation.			100% compliance has been		
		states sensitivity shall be			achieved.		1
	-	nate year thereafter unless					
	_	d by compliance with 14.4.5.3.3.					
	14.4.5.3.5 states smoke detectors or smoke alarms						
		sitivity outside the listed and					
	_	range shall be cleaned and					
		eplaced. Section 14.6.2.4 states					
	a record of all inspe	_					
		be provided that includes all					
		ion requested in Figure					
		cient practice could affect all					
	residents, staff and	visitors.					
	Findings include:						
	Raced on review of	the fire alarm system					
		or's "Fire Alarm Inspection"					
	_	ed 08/08/22 with the					1
		tor during record review from					1
		o.m. on 06/12/23, four smoke					
	_	sitivity testing. The					
		ats" section of the 08/08/22					
	inspection report sta						
		The 08/08/22 inspection report					
		smoke detector locations as					
		M", "Hall by Courtyard					
		ing Machine" and "O/S Social					
		epair or replace documentation					
		detectors which failed					
		n or after 08/08/22 was not					
	available for review	v. Keview of the	1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155665	B. W	ING		06/12	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	ROVIDER OR SUPPLIEF	8			NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	l VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		its" section of the fire alarm					
		ontractor's "Fire Alarm					
	-	entation dated 11/25/22 stated					
		ailed sensitivity and need 25/22 fire alarm system					
	-	entified the same smoke					
		which failed 08/08/22					
		Based on interview at the time					
		e Maintenance Director stated					
		ector locations passed					
		nal testing conducted on					
	-	/23 but agreed repair or					
	replacement documentation for the four smoke						
	•	n or after 08/08/22 was not					
		at the time of the survey.					
		Ž					
	These findings were	e reviewed with the Executive					
		rector of Maintenance during					
	the exit conference.						
	3.1-19(b)						
	3. Based on observa	ation and interview, the facility					
		ne fire alarm system to assure					
		time and date information in					
		e requirements of NFPA 101-					
		ons 19.3.4 and 9.6 and NFPA 72					
	· ·	ions 14.1, 14.1.1. This deficient					
		t all residents, staff and					
	visitors.						
	Findings include:						
	Based on observation	ons with the Maintenance					
		our of the facility from 1:00 p.m.					
	_	12/23, the time of day for the					
	-	trol panel was incorrect. The					
		ne of day as 2:56 p.m. at 1:31					
		ay for the remote fire panel					
	-	entrance lobby was also					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES		OM	IB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	ľ	ILDING	onstruction 01	(X3) DATE SURVEY  COMPLETED  06/12/2023	
	PROVIDER OR SUPPLIER			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	panel read the time Based on interview observations, the M the main fire alarm fire alarm panel did day.  These findings wer Director and the Di the exit conference.  3.1-19(b)  NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required ence exits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containin combustible mate hardware. Roller I CMS regulation. If apply to auxiliary flammable or com Clearance betwee covering is not ex doors complying v if provided with a	control panel and the remote and display the correct time of the reviewed with the Executive rector of Maintenance during the corridor openings in other corridor openings in other corridor openings, as areas resist the passage made of 1 3/4 inch a wood or other material and fire for at least 20 fully sprinklered smoke the only required to resist the condition of the corridor doors and doors and flammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain					

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applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/12/2023 155665 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3. unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 K363-E 06/26/2023 failed to ensure 2 of 61 corridor doors to resident What corrective action(s) will be sleeping rooms had no impediment to closing and accomplished for those residents latching into the door frame and would resist the found to have been affected by the passage of smoke. This deficient practice could deficient practice? affect over 50 residents, staff and visitors. The one-half inch hole in the corridor door for room C107, just Findings include: above the handle, has been appropriately repaired. Based on observations with the Maintenance The drain line, electrical cord and the dehumidifier units have Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the drain line and the been removed from the building electrical cord for an operating dehumidifier stored in the corridor outside Room B108 was taped to How other residents having the the floor and to the corridor door to resident potential to be affected by the sleeping Room B108. Room B108 was occupied same practice will be identified by a resident and the corridor door to Room B108 and what corrective action(s) will was in the fully open position and was prevented be taken? from closing by the drain line and the electrical cord. In addition, a one half inch in diameter hole All Residents residing in the was noted in the corridor door to resident facility could be affected. sleeping Room C107 just above the door handle which would not resist the passage of smoke. What measures will be put into

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

	OF CORRECTION	IDENTIFICATION NUMBER  155665	A. BUILDING B. WING	<u>01</u>	COMPLETED 06/12/2023
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the drain line and the corridor door to Roo latching into the door corridor door to Roo passage of smoke.  These findings were	at the time of the aintenance Director agreed e electrical cord prevented the om B108 from closing and or frame the hole in the om C107 would not resist the ereviewed with the Executive aintenance Director during the		place and what systemic char will be made to ensure that the deficient practice does not reconstructed.  1. Inspection of the Fire Palenternal Clocks has been added the Maintenance Supervisor's ongoing inspection schedule.  2. Ongoing review by the Ensure scheduled inspections being completed and followed on as planned.  How the corrective action(s) we monitored to ensure the defice practice will not recur, i.e., who quality assurance program with put into place?  1. For Quality Assurance, Maintenance Supervisor, or he designee, will review the Fire Panel Internal Clocks 5 days week for 2 weeks, then week 6 weeks, then monthly for an additional 4 months.  2. Findings will be reported the ED and the QA Committe 6 months and will continue un 100% compliance has been achieved.	e cur?  anel ed to so are d to so are d up  vill be sient at d be determined to the so are d to so are
K 0500 SS=F Bldg. 01	Section 18.5 and requirements that				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	
		155665	B. W	NG 06/12/20:			/2023
NAME OF F			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	<b>C</b>			NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	_	with the applicable Life					
	,	FPA standard citation,					
	should be included on Form CMS-2567. Based on record review, observation and		I K O	500	K500-F		06/26/2023
		ty failed to ensure all fuel fired	K U	300	What corrective action(s) will l	he	00/20/2023
		urrent inspection certificates			accomplished for those reside		
		heaters were in safe operating			found to have been affected b		
		01, Section 19.1.1.3.1 requires			deficient practice?		
		to be designed constructed,			,		
		rated to minimize the			The Pressure Vessel Certifica	tes	
		emergency requiring the			were discovered after Surveyo	or left	
	_	pants. This deficient practice			the facility. They show that al	l	
	affects all residents	, staff and visitors.			units are up to date.		
	Findings include:				How other residents having th	e	
	i mamga maraas				potential to be affected by the		
	Based on record rev	view with the Maintenance			same practice will be identified		
		a.m. to 12:40 p.m. on 06/12/23,			and what corrective action(s)		
		ertificates from the State of			be taken?		
	Indiana for all fuel	fired water heaters in the					
	facility were not av	ailable for review. Based on			All Residents residing in the		
	observations with the	ne Maintenance Director			facility could be affected.		
	_	facility from 1:00 p.m. to 3:20					
	_	he following fuel fired heaters			What measures will be put int		
		t Certificate of Inspection			place and what systemic char	-	
		n the State of Indiana:			will be made to ensure that the		
	a. the fuel fired wat IN266152.	er heater identified as			deficient practice does not rec	cur?	
		er heater identified as			Inspection of the Pressu	re	
	IN349205.				Vessel Certificates documenta		
	c. the fuel fired wat	er heater identified as			has been added to the		
	IN370483.				Maintenance Supervisor's ong	going	
	Based on interview				inspection schedule.		
		laintenance Director stated			2. Ongoing review by the E		
		of Inspection documentation			his designee, will be performe		
		the Life Safety Code book for			ensure scheduled inspections		
		ed the aforementioned fuel			being completed and followed	up	
		t have current Certificate of			on as planned.		
	_	ntation from the State of					
	Indiana.		1		Ī		1

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

PRINTED: 06/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/12/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112			
		e reviewed with the Executive aintenance Director during the		How the corrective action(s) we monitored to ensure the deficing practice will not recur, i.e., who quality assurance program with put into place?  1. For Quality Assurance, Maintenance Supervisor, or how designee, will review the Presure Vessel Certificates document 5 days a week for 2 weeks, the weekly for 6 weeks, then monitor an additional 4 months.  2. Findings will be reported	tent at at ll be the is sure ation en thly			
				the ED and the QA Committee 6 months and will continue un 100% compliance has been achieved.				
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	ay be used instead of						
	failed to provide do conducted on the se	view and interview, the facility cumentation of a fire drill second shift and third shift for 1 deficient practice affects all visitors.	K 0712	K712-F What corrective action(s) will accomplished for those reside found to have been affected be deficient practice?	ents			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPL	
		155665	B. W	ING		06/12/	2023
	PROVIDER OR SUPPLIER		<u> </u>	701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	DOLLAR DE LA CARRACTERIA DEL CARRACTERIA DE LA C		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
	`				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
	Findings include:				The Fire Drill Schedule has be	en	
TAG	Findings include:  Based on review of Drills" and "Fire Dr the Maintenance Di from 9:50 a.m. to 12 documentation of a second shift in the f November, December review. In addition conducted on the th (January, February, available for review time of record review stated the facility of and agreed documer on the second and the formentioned calcavailable for review. These findings were	endar quarters was not		TAG	The Fire Drill Schedule has be corrected indicating the need of drill per shift per quarter at a minimum.  How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) to be taken?  All Residents residing in the facility could be affected.  What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not reconstructed.  Inspection of the Fire Drischedule has been added to the Maintenance Supervisor's ongoinspection schedule.  Ongoing review by the Elhis designee, will be performed ensure scheduled inspections being completed and followed on as planned.  How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place?  The Quality Assurance, the Maintenance Supervisor, or his	een for 1  e d will  o ges e ur? ill he going D, or d to are up will be ent at I be	DATE
					designee, will review the Fire I Schedule 5 days a week for 2 weeks, then weekly for 6 week		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155665	B. W	NG		06/12/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				NRY STREET		
MAJESTI	C CARE OF NORT	H VERNON	NORTH VERNON, IN 47265				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					then monthly for an additional months. 2. Findings will be reported	to	
					the ED and the QA Committee		
					6 months and will continue un	til	
					100% compliance has been		
					achieved.		
K 0761 SS=F Bldg. 01							
3 -	Based on record rev	riew, observation and	K 0	761	K761-F		06/26/2023
		ty failed to ensure annual		701	What corrective action(s) will be	ре	00/20/2023
	inspection and testing	ng of all fire door assemblies			accomplished for those reside		
	were completed in a	accordance of LSC 19.1.1.4.1.1.			found to have been affected b	y the	
	Communicating ope	enings in dividing fire barriers			deficient practice?		
		.1 shall be permitted only in					
		be protected by approved			The Fire Door Inspection		
	-	or assemblies. (See also Section			documentation has been upda		
		penings required to have a fire			showing the itemized list which		
		Table 8.3.4.2 shall be			now includes reviewing all For		
		ed, listed, labeled fire door			Doors in the area scheduled for	or	
		window assemblies and their			inspection.		
		ware, including all frames,			l., ., .,		
	closing devices, and				How other residents having the		
		requirements of NFPA 80, pors and Other Opening			potential to be affected by the		
		as otherwise specified in this			same practice will be identified		
		ection 5.2.1 states fire door			and what corrective action(s) which is the taken?	WIII	
		inspected and tested not less			be taken:		
		written record of the			All Residents residing in the		
	-	signed and kept for inspection			facility could be affected.		
	-	80, 5.2.4.1 states fire door					
		visually inspected from both			What measures will be put into	0	
		verall condition of door			place and what systemic chan		
	assembly.				will be made to ensure that the	•	
	•				deficient practice does not rec		
	NFPA 80, Section 5	5.2.4.2 states as a minimum, the			•		
	following items sha	ll be verified:			1. Inspection of the Fire Do	or	
	(1) No open holes o	r breaks exist in surfaces of			Inspection has been added to	the	

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

Event ID:

2X7521

Facility ID: 010996

If continuation sheet Page 20 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	
		155665	B. WI	NG		06/12/	/2023
MANUT OF T	DROLUDED OF COMPY			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		701 HE	NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	I VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	either the door or fr	R LSC IDENTIFYING INFORMATION		TAG		•	DATE
		light frames, and glazing beads			Maintenance Supervisor's ong inspection schedule.	joing	
		ely fastened in place, if so			Ongoing review by the E	D or	
	equipped.	ery fastefied in place, if so			his designee, will be performe		
		e, hinges, hardware, and			ensure scheduled inspections		
		eshold are secured, aligned,			being completed and followed		
		er with no visible signs of			on as planned.	чÞ	
	damage.	<del></del>					
	(4) No parts are mis	ssing or broken.			How the corrective action(s) w	ill be	
		s do not exceed clearances			monitored to ensure the defici		
	listed in 4.8.4 and 6	5.3.1.7.			practice will not recur, i.e., who		
	(6) The self-closing	device is operational; that is,			quality assurance program wil	l be	
	the active door com	pletely closes when operated			put into place?		
	from the full open p	oosition.					
	(7) If a coordinator	is installed, the inactive leaf			1. For Quality Assurance, t	he	
	closes before the ac	etive leaf.			Maintenance Supervisor, or hi	s	
		are operates and secures the			designee, will review the Fire	Door	
	door when it is in the	-			Inspection 5 days a week for 2	2	
		vare items that interfere or			weeks, then weekly for 6 weel		
		are not installed on the door or			then monthly for an additional	4	
	frame.				months.		
		fications to the door assembly			2. Findings will be reported		
	_	ed that void the label.			the ED and the QA Committee		
		edge seals, where required, are			6 months and will continue un	til	
	-	their presence and integrity.			100% compliance has been		
	•	ice could affect all residents,			achieved.		
	staff and visitors.						
	Findings include:						
	Based on review of	Direct Supply TELS Logbook					
		pors, Locks and Alarms: Test					
		and Locks" documentation					
	with the Maintenan	ce Director during record					
	review from 9:50 a.	.m. to 12:40 p.m. on 06/12/23, fire					
	door inspection doo	cumentation for the facility					
	within the most rec	ent twelve months was not					
	itemized by location	n. In addition, it was unclear if					
	the inspection docu	mentation included all items					
	listed in NFPA 80.	Section 5.2.4.2. The					

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

PRINTED: 06/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155665	B. Wl	NG		06/12/	/2023	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	L			NRY STREET			
MAJESTI	IC CARE OF NORT	TH VERNON			VERNON, IN 47265			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		LS Logbook documentation						
		on of doors listed in the "a						
		all" and "d hall". As a result, it						
		nspection documentation was						
		ns in each of the four halls or						
		ations in the four halls. Based						
		time of record review, the for stated additional fire door						
		ntation was not available for						
	review and agreed t							
		not itemized by fire door						
		observations with the						
		or during a tour of the facility						
		:20 p.m. on 06/12/23, the corridor						
	_	storage and transfilling room						
		it door of the facility in the						
		uipped with a 1-hour fire						
	resistance rating lab	oel. Four liquid oxygen						
		ty 'E' type oxygen cylinders						
	were stored in the ro	oom. The corridor door to the						
	oxygen storage and	transfilling room is not in one						
	of the four halls ide	ntified in the TELS Logbook						
	documentation.							
	These findings were	e reviewed with the Executive						
	_	aintenance Director during the						
	exit conference.							
	3.1-19(b)							
K 0914	NFPA 101							
SS=F		s - Maintenance and						
Bldg. 01	Testing	, Maintonanoc and						
	_	s - Maintenance and						
	Testing							
	_	ceptacles at patient bed						
		re deep sedation or general						
		inistered, are tested after						
		replacement or servicing.						
		is performed at intervals						
			1				I	

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

Event ID:

2X7521

Facility ID: 010996

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	ETED
		155665	B. W	ING		06/12/	2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	I VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	I -	ented performance data.					
	I	sted as hospital-grade at					
	these locations are tested at intervals not exceeding 12 months. Line isolation monitors						
	_	are tested at intervals of					
		to 1 month by actuating					
	-	n per 6.3.2.6.3.6, which					
		ual and audible alarm. For					
		utomated self-testing, this					
		formed at intervals less					
	1	2 months. LIM circuits are					
	I -	.2 after any repair or					
	· ·	electric distribution system.					
		tained of required tests and					
	associated repairs						
	containing date, ro	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)						
		view, observation and	K 0	914	K914-F		06/26/2023
	interview; the facili	-			What corrective action(s) will I	be	
		lectrical outlet receptacle			accomplished for those reside		
	_	ent sleeping rooms was			found to have been affected b	y the	
		in accordance with NFPA 99.			deficient practice?		
		are Facilities Code, 2012					
		.4.1.3 states receptacles not			The Electrical Receptacle Tes	-	
		ade at patient bed locations			has been and will continue to		
		ere deep sedation or general			performed at least annually at		
		tested at intervals not			patient bed locations. A new		
	1	ns. NFPA 99, Health Care 12 Edition, Section 6.3.4.1.1			schedule has been put into pla	ace.	
					How other regidents having the		
		e receptacles testing shall be ial installation, replacement or			How other residents having the potential to be affected by the		
	_	rice. Section 6.3.3.2,			same practice will be identified		
		in Patient Care Rooms requires			and what corrective action(s)		
		•			be taken?	VVIII	
	the physical integrity of each receptacle shall be				be taken:		
	confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and				All Residents residing in the		
					facility could be affected.		
		in each electrical receptacle			lasing codia so directed.		
		and retention force of the			What measures will be put into	o l	

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

Event ID:

2X7521

Facility ID: 010996

If continuation sheet Page 23 of 26

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155665	B. W	ING		06/12/2023	
N. 100 000	AN OLUMBIA OR SYMPT		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH VERNON, IN 47265		<u>,                                      </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLE	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG		DATI	E
		each electrical receptacle			place and what systemic char	~	
		e receptacles) shall be not less			will be made to ensure that the		
		ounces). Section 6.3.4.2.1.2			deficient practice does not rec	ur?	
	states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication				4 The Fleetwicel December	_	
		e met, or have failed to meet,			The Electrical Receptach  Testing Inspection has been	e	
		quirements of this chapter.			Testing Inspection has been added to the Maintenance		
	This could affect al	-			Supervisor's ongoing inspection	n	
	This could affect at	residents.			schedule.	71	
	Findings include:				Ongoing review by the E	or	
					his designee, will be performe		
	Based on record rev	view with the Maintenance			ensure scheduled inspections		
		a.m. to 12:40 p.m. on 06/12/23,			being completed and followed		
		ceptacle inspection and testing			on as planned.	'	
	documentation for t	the most recent twelve month					
	period was not avai	lable for review. Based on			How the corrective action(s) w	ill be	
	interview at the tim	e of record review, the			monitored to ensure the defici	ent	
	Maintenance Direct	tor agreed electrical receptacle			practice will not recur, i.e., wh	at	
	inspection and testi	ng documentation within the			quality assurance program wil	be	
		month period was not			put into place?		
		Based on observations with					
		rector during a tour of the			1. For Quality Assurance, t		
		.m. to 3:20 p.m. on 06/12/23,			Maintenance Supervisor, or hi		
		oms have non-hospital grade			designee, will review the Elect		
	receptacles installed	d in the room.			Receptacle Testing Inspection		
					days a week for 2 weeks, ther		
	_	e reviewed with the Executive			weekly for 6 weeks, then mon	hly	
		aintenance Director during the			for an additional 4 months.	_	
	exit conference.				2. Findings will be reported		
	2.1.10(1)				the ED and the QA Committee		
	3.1-19(b)				6 months and will continue un	."	
					100% compliance has been achieved.		
					acrileved.		
K 0916	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 01	I	s - Essential Electric					
J	System Alarm Ani						
	1 -	ator that is storage battery	- [				
		ed to operate outside of the					

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPI	
		155665	B. W.	ING		06/12	/2023
NAME OF F	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP COD		
144 IFOT	IO OADE OF NODE	CLIVEDNON			ENRY STREET		
MAJEST	IC CARE OF NORT	H VERNON		NORTH	H VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n a location readily					
		ating personnel. The					
	annunciator is hard-wired to indicate alarm conditions of the emergency power source. A						
	-	uter system (e.g., building					
	for the alarm annu	n) is not to be substituted					
	6.4.1.1.17, 6.4.1.1						
		on and interview, the facility	K 0	016	K916-F		06/26/2023
		f 1 emergency generator		710	What corrective action(s) will	he	00/20/2023
		was in proper operating			accomplished for those reside		
		icient practice could affect all			found to have been affected b		
	residents, staff and	•			deficient practice?	, y 1110	
					The 3-position switch ha	as	
	Findings include:				been cleaned and is operating		
					it should following this service	-	
	Based on observation	ons with the Maintenance			2. A new 3-position switch I		
	Director during the	initial walk through of the			been ordered and will be insta		
	_	on 06/12/23, the "overcrank"			when received.		
	status indicator ligh	t for the wall mounted remote					
	annunciator panel le	ocated at the C Hall nurse's			How other residents having th	ne	
	station was illumina	ated in red indicating system			potential to be affected by the		
	trouble. The Maint	enance Director tried to reset			same practice will be identified	d	
	the annunciator pan	el indicator light by pushing			and what corrective action(s)	will	
		the panel but the status			be taken?		
	_	ined illuminated in red. The					
	•	d emergency generator located			All Residents residing in the		
	_	on the south side of the			facility could be affected.		
	_	operation. Based on interview					
		oservations, the Maintenance			What measures will be put int		
		vas not aware of any generator			place and what systemic char	-	
		e emergency generator would			will be made to ensure that the		
		were to lose power but agreed			deficient practice does not rec	cur?	
		tus indicator light for the wall					
		nunciator panel was			Inspection of the		
		on observations with the			Annunciator Panel has been		
		tor during a tour of the facility			added to the Maintenance		
	_	:20 p.m. on 06/12/23, the			Supervisor's ongoing inspection	on	
		indicator light remained			schedule.	_	
l	illuminated.		ı		2. Ongoing review by the F	D or	I

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/28/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOI	R MEDICARE & MEDIC	AID 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>01</u>		COMPLETED	
		155665	B. WING		06/12/2023	
			CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				701 HENRY STREET		
MAJESTIC CARE OF NORTH VERNON				NORTH VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			
				his designee, will be performe	d to	
	These findings were reviewed with the Executive Director and the Maintenance Director during the			ensure scheduled inspections	are	
				being completed and followed up on as planned.		
	exit conference.					
	3.1-19(b)			How the corrective action(s) will be		
				monitored to ensure the deficient	ent	
				practice will not recur, i.e., who	at	
				quality assurance program will be		
				put into place?		
				For Quality Assurance, the		
				Maintenance Supervisor, or his		
				designee, will review the		
				Annunciator Panel 5 days a w	eek	
				for 2 weeks, then weekly for 6		
				weeks, then monthly for an		
				additional 4 months.		
				2. Findings will be reported	to	
				the ED and the QA Committee		
				6 months and will continue un	til	
				100% compliance has been		

achieved.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2X7521 Facility ID: 010996 If continuation sheet Page 26 of 26