PRINTED: 08/26/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION LIDENTIFICATION NUMBER 155491		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIED			1029 E	ADDRESS, CITY, STATE, ZIP COD 5 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 08/14 Facility Number: 0 Provider Number: 100 At this Emergency Care of Connersvil with Emergency Pr Medicare and Med and Suppliers, 42 0 The facility has 160 the survey, the cens	200316 155491 286370 Preparedness survey, Majestic le was found in compliance eparedness Requirements for icaid Participating Providers 2FR 483.73	E 00	00	Please accept this Plan of Correction as our credible allegation of compliance. We respectfully request a desk rev in lieu of a post survey revisit.	<i>i</i> iew	
K 0000 Bldg. 01	A Life Safety Code Licensure Survey v Department of Hea 483.90(a). Survey Date: 08/1- Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety Connersville was for	Recertification and State was conducted by the Indiana lth in accordance with 42 CFR 4/24 200316 155491 286370 Code survey, Majestic Care of bund not in compliance with	K 00	000	Please accept this Plan of Correction as our credible allegation of compliance. We respectfully request a desk rev in lieu of a post survey revisit.	⁄iew	
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE		TITLE		(X6) DATE

Matt Elwell **HFA** 08/22/2024

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

Event ID: AFQM21 Facility ID: 000316

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

PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		r í	JILDING	01	COMPL 08/14/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD 5TH STREET		
MAJEST	IC CARE OF CONN	ERSVILLE		CONNE	RSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupated The facility consisted the East Building (2 which were determined construction and full has a fire alarm systime corridors and sparting facility has a cacensus of 81 at the total All areas where resing were sprinkled and a services were sprinkled and	42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing incies, and 410 IAC 16.2. and of two, one story buildings, and the West Building (1), and the West Building (1), and to be of Type V (111) and to be of Type V (111) are with smoke detection in access open to the corridor. The pacity of 166 and had a sime of this survey. The providing facility are all areas providing facility are are protected by a fire fire resistance rating are protected by a fire four fire resistance rating are protected by a fire four fire resistance rating are protected by a fire four fire resistance rating are protected by a fire four fire resistance rating are protected by a fire four fire resistance rating are protected by a fire four fire resistance rating are protected by a fire four fire extinguishing system areas shall be separated by smoke resisting as in accordance with 8.4.					

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

Event ID:

AFQM21 Facility ID: 000316

If continuation sheet Page 2 of 14

STATE	MENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>01</u>	COMPLETED
		155491	B. WING		08/14/2024
			STR	EET ADDRESS, CITY, STATE, ZIP COD	
NAME (OF PROVIDER OR SUPPLIE	R	102	29 E 5TH STREET	
MAJE	STIC CARE OF CON	NERSVILLE	СО	NNERSVILLE, IN 47331	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPRO	
TAG		R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)	DATE
		that are deficient in			
	REMARKS.				
	19.3.2.1, 19.3.5.9				
	Area	Automatic Sprinkler			
	Separation	-			
		l-Fired Heater Rooms			
		er than 100 square feet)			
	, -	nance, and Paint Shops			
	· ·	ooms (exceeding 64			
	gallons)				
	e. Trash Collectio	n Rooms			
	(exceeding 64 ga				
	f. Combustible St	orage Rooms/Spaces			
	(over 50 square for	•			
		classified as Severe			
	Hazard - see K32				
		on and interview, the facility	K 0321	What corrective action wi	II be 08/22/2024
		corridor doors to 1 of over 4		accomplished for those	
		ere provided with a		residents found to have b	een
		which would cause the door to and latch into the door frame.		affected by the deficient	
		tice could affect 2 residents in 1		practice. No residents were found to	havo
	smoke compartmer			been affected by the deficie	
	Smoke comparanter			practice. Room #806 was o	
	Findings include:			and boxes removed and th	
	3			converted into a resident ro	
	Based on observati	ons and interviews during a		Room #807 has had a clos	
	tour of the facility	with the Executive Director,		added to it.	
	Maintenance Direc	tor and Regional Facilities		How other residents having	ng the
		tive on 08/14/24 between 12:20		potential to be affected by	the
	1 -	, the corridor doors to the		same deficient practice w	ill be
		is areas did not meet the		identified and what correc	tive
	requirements for protection of a hazardous area: a) Resident Room #308 which was larger than 50			action(s) will be taken.	
				All residents have the pote	
	_	tained over 35 boxes of		be affected by the deficient	
	supplies was not self-closing.		practice. A complete facility		
				was conducted to ensure the	
		at the time of observation, the tor agreed the aforementioned		storage room doors had clo	sures
	i iviaintenance Direc	tor agreed the aforementioned	ı	with no deficiencies noted.	i i

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

PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		155491	B. WI	NG		08/14	/2024
NAME OF P	DOMDED OF CHIPPLYEE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIEF	C .		1029 E	5TH STREET		
MAJESTI	IC CARE OF CONN	NERSVILLE		CONNE	ERSVILLE, IN 47331		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ous storage area, and the door			What measures will be put in	ito	
to the room did not self-close.				place and what systematic			
				changes will be made to			
This finding was acknowledged by the Executive				ensure that the deficient			
		nce Director and Regional			practice does not recur.		
		epresentative at the time of			The Executive Director educate	ted	
	_	nin at the exit conference with			the Maintenance Director on		
		etor, Maintenance Director and			8/22/24 on the need for all sto	-	
	-	Support representative all			rooms to have closures and lo		
	present.				on them. The Executive Direct		
	2.1.10(1)				Maintenance Director, or design	gnee	
	3.1-19(b)				will complete an entire facility	-4	
					audit once weekly to ensure the		
					all rooms that can be identified		
					storage rooms are complete w closures.	/IUI	
					How the corrective action(s)		
					will be monitored to ensure t	ho	
					deficient practice will not	iie	
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place.	ut	
					The Executive Director or		
					Maintenance Director will bring	n	
					any deficiencies to morning	9	
					meeting so they can be correct	ted	
					in real time. The Executive		
					Director will bring results of the	e.	
					audits to monthly QAPI meetir		
					review with Department Heads	-	
					determine if additional action of		
					auditing needs to be added in		
					order to remain in compliance		
					Audits will be reviewed by the		
					QAPI Committee until such a	time	
					consistent substantial complia		
					has been achieved as determi		
					by the committee.		
					,		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING 01 COMPLETI				
AND PLAN	OF CORRECTION	155491	B. WING 08/14/2				
		133491	D. W			00/14/	2024
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
MAJESTI	C CARE OF CONN	IERSVILLE			5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0341	NFPA 101						
SS=E	Fire Alarm System						
Bldg. 01	Fire Alarm System						
	-	m is installed with systems					
	·	approved for the purpose in					
		IFPA 70, National Electric 72, National Fire Alarm					
		ffective warning of fire in any					
	•	g. In areas not continuously					
		n is installed at each fire					
	•	In new occupancy,					
		nstalled at notification					
	appliance circuit p	ower extenders, and					
	supervising station	n transmitting equipment.					
	Fire alarm system	wiring or other					
	-	s are monitored for					
	integrity.						
	18.3.4.1, 19.3.4.1,						
		on and interview, the facility	K 0	341	What corrective action will be)	08/22/2024
		1 fire alarm systems was			accomplished for those	_	
		nce with 19.3.4.1. LSC 9.6.1.3 a system to be installed, tested,			residents found to have beer	1	
	-	ccordance with NFPA 70,			affected by the deficient practice.		
		Code and NFPA 72, National			No residents were found to ha	\/A	
		NFPA 72, 17.7.4.1 requires in			been affected by the deficient	VC	
		handling systems, detectors			practice. The smoke detector i	n	
		where air flow prevents			question was moved to 39 incl		
		ectors. This deficient practice			of the air source.		
	could affect 10 resid	dents in one smoke			How other residents having t	he	
	compartment.				potential to be affected by th	е	
					same deficient practice will b	e	
	Findings include:				identified and what corrective	9	
					action(s) will be taken.		
		ons and interviews during a			All residents have the potentia	I to	
	•	with the Executive Director,			be affected by the deficient	: 4	
		or and Regional Facilities			practice. A complete facility au	alt	
	Support representative on 08/14/24 between 12:20 p.m. and 3:10 p.m., in the corridor by the Kitchen in the East Building there was a smoke detector			was conducted by the Maintenance Director to ensur	·o		
				there were no smoke detectors			
		t of an air supply where air			within 36 inches of an air sour		
		an sapply where an					

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Event ID:

AFQM21 Facility ID: 000316

If continuation sheet Page 5 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLET	
		155491	B. WI	NG		08/14/20	024
	PROVIDER OR SUPPLIER		•	1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	116	DATE
	flow would prevent	proper operation of the			with no additional deficiencies		
	detector. The MD s	tated that as ceiling tiles were			identified.		
	being replaced that	the one containing the smoke			What measures will be put ir	nto	
	detector was installed	ed in the wrong grid.			place and what systematic		
					changes will be made to		
	_	knowledged by the Executive			ensure that the deficient		
		nce Director and Regional			practice does not recur.		
		epresentative at the time of			The Executive Director educate	ted	
		in at the exit conference with			the Maintenance Director on		
		tor, Maintenance Director and			8/22/24 on importance of not		
	_	Support representative all			having a smoke detector withi	n 36	
	present.				inches of an air source. The		
					Maintenance Director or desig		
	3.1-19(b)				will conduct a complete facility	/	
					audit weekly for 3 months to		
					ensure there are no smoke		
					detectors within 36 inches of a	an	
					air source.		
					How the corrective action(s)		
					will be monitored to ensure t	the	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place.		
					The Executive Director or		
					Maintenance Director will bring any deficiencies to morning	9	
					meeting so they can be correct	rted	
					in real time. The Executive	JiGU	
					Director will bring results of the		
					audits to monthly QAPI meeting		
					review with Department Head	_	
					determine if additional action of		
					auditing needs to be added in		
					order to remain in compliance		
					Audits will be reviewed by the		
					QAPI Committee until such a		
					consistent substantial complia		
					has been achieved as determine		
					by the committee		

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Event ID:

AFQM21 Facility ID: 000316

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155491	B. WI	NG		08/14/	2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heati HVAC - Any Heati Any heating device heating plant, is de combustible mater device, and has a and shut down equ excessive tempera fuel fired, the devic * is chimney or ver * takes air for com * provides for a co from occupied are 19.5.2.2 Based on observation failed to ensure 1 of Building was provid from the outside for equipment. NFPA any fuel-fired heatin heating plant, shall they shall take air for outside. This deficit atmosphere rich wit could cause physical laundry room. Findings include: Based on observation tour of the facility we Maintenance Direct Support representation p.m. and 3:10 p.m., fired dryers with 2 co provide air from the vent for the dryer or container full of tow	ing Device ing Device ing Device ing Device ing Device ing of the than a central resigned and installed so rials cannot be ignited by safety feature to stop fuel uipment if there is rature or ignition failure. If ce also: Int connected. Intubustion from outside. Intubustion system separate rea atmosphere. In and interview, the facility of 1 laundry rooms in the West ded with intake combustion air rooms containing fuel fired of 101, Section 19.5.2.2(2) requires of device, other than a central be designed and installed so or combustion directly from the rent practice could create an office carbon monoxide which office problems for all staff in the ons and interviews during a with the Executive Director, or and Regional Facilities ive on 08/14/24 between 12:20 the laundry room had 2 fuel corresponding wall vents to re outside. The dryer outside on the left was obstructed by a vels which restricted the	K 0.		What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by deficient practice. The bucket towels that could have been restricting the air flow were removed from the area. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential be affected by the deficient practice. A thick line of red tap was added to the floor as a reminder not to put anything put the line that could possibly resair flow or obstruct the vents. What measures will be put in place and what systematic	the and the e e e e e e e e e e e e e e e e e e	08/22/2024
	outside air from ente	ering the room.	1		changes will be made to		

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING 01 COMPLE B. WING 08/14/2			ETED		
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF This finding was ac Director, Maintenar Facilities Support re observation and aga the Executive Direct	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION knowledged by the Executive nee Director and Regional expresentative at the time of ain at the exit conference with attor, Maintenance Director and Support representative all		ID PREFIX TAG	ensure that the deficient practice does not recur. The Executive Director or Housekeeping Supervisor educated the laundry and housekeeping staff on 8/22/2 there could be no obstruction the vents in the laundry room. The Maintenance Director or Housekeeping Supervisor will the laundry rooms 5 times we for one month and then week 2 months to ensure there are obstructions to the vents in the laundry rooms. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place. The Executive Director, or Housekeeping Supervisor will any deficiencies to morning meeting so they can be corre in real time. The Executive Director will bring results of the audits to monthly QAPI meetir review with Department Head determine if additional action auditing needs to be added in order to remain in compliance Audits will be reviewed by the QAPI Committee until such a consistent substantial compliance has been achieved as determine by the committee.	4 that s to s. l audit ekly ly for no e the leng to s to or less to or less to or less to ance	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AFQM21 Facility ID: 000316

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIEF		1029 E	ADDRESS, CITY, STATE, ZIP CODESTH STREET ERSVILLE, IN 47331)
(X4) ID PREFIX TAG K 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	CTION (X5) ILD BE COMPLETION ROPRIATE DATE
Bldg. 03	Licensure Survey w Department of Head 483.90(a). Survey Date: 08/14 Facility Number: 0 Provider Number: 100 At this Life Safety of Connersville was for Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupant The facility consists the East Building (2) which were determined to the construction and furth has a fire alarm system of the facility has a consus of 81 at the All areas where reserved.	200316 155491 286370 Code survey, Majestic Care of bund not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies, and 410 IAC 16.2. ed of two, one story buildings, 22) and the West Building (1), ined to be of Type V (111) Illy sprinkled. Each building tem with smoke detection in paces open to the corridor. Apacity of 166 and had a time of this survey.	K 0000	Please accept this Plan of Correction as our credible allegation of compliance, respectfully request a dein lieu of a post survey re	e We sk review
IZ 0224		mpleted on 08/16/24			
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure			

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (0.3) COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			03	COMPL	
		155491	B. WIN	NG		08/14/	2024
	PROVIDER OR SUPPLIER			1029 E	ADDRESS, CITY, STATE, ZIP COD 5TH STREET ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T .	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 03	barrier having 1-hd (with 3/4 hour fire automatic fire extinuction accordance with 8 approved automatic option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	are protected by a fire our fire resistance rating rated doors) or an nguishing system in 8.7.1 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. f-closing or and permitted to have applied protective plates that inches from the bottom of					
	REMARKS. 19.3.2.1, 19.3.5.9	that are deficient in					
	b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K32	e-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops froms (exceeding 64 In Rooms lons) frage Rooms/Spaces eet) classified as Severe	K 03	21	What corrective action will b	e	08/22/2024
	failed to ensure the hazardous rooms we self-closing devices automatically close	corridor doors to 2 of over 10 ere provided with a which would cause the door to and latch into the door frame. ice could affect 4 residents in 2	K 03	<i>L</i> 1	accomplished for those residents found to have been affected by the deficient practice. No residents were found to have been affected by the deficient been affected by the deficient.	1	00/22/2024

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Event ID:

 $AFQM21 \quad \text{Facility ID:} \quad 000316 \qquad \qquad \text{If continuation sheet} \quad \text{Page 10 of 14}$

MAJESTIC CARE OF CONNERSVILLE (X04) ID SUMMARY STATEMENT OF DEFICIENCIE REGULATORY OR LSC IDENTIFYING INFORMATION FREIX TAG Findings include: Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support representative on 80/14/2-b thewen 12:20 p.m. and 3:10 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Room #806 which was larger than 50 square feet and contained over 10 boxes of supplies was not self-closing. b) Resident Room #807 which was larger than 50 square feet and contained over 10 boxes of supplies was not self-closing. Based on interview at the time of observation, the Maintenance Director and Regional Facilities Support representative at the time of observation and again at the exit conference with the Executive Director, Maintenance Director and Regional Facilities Support representative all present. 3.1-19(b) STREIT ADROBALLS, CITY, STATE, JPL COO 1029 6 5TH STREET CONNERSVILLE, IN 47331 D RAGIORATORY OR LSC IDENTIFYING RPORMATION TAG PREHIX TAG TAG PREHIX	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155491		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/14/2024		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support representative all present. Based on interview on 08/14/24 between 12:20 p.m. and 3:10 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Room #807 which was larger than 50 square feet and contained over 10 boxes of supplies was not self-closing. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned rooms were hazardous strange areas, and the doors to the rooms were not self-closing. This finding was acknowledged by the Executive Director, Maintenance Director and Regional Facilities Support representative at the time of observation and again at the exit conference with the Executive Director, Maintenance Director and Regional Facilities Support representative all present. 3.1-19(b) COMPLETION TAG TAG PREFIX TAG PREF					1029 E	5TH STREET		
Findings include: Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support representative on 08/14/24 between 12:20 p.m. and 3:10 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Room #806 which was larger than 50 square feet and contained over 8 boxes of supplies was not self-closing. Based on interview at the time of observation, the Maintenance Director and Regional Facilities Support representative at the time of observation and again at the exit conference with the Executive Director, Maintenance Director and Regional Facilities Support representative all present. 3.1-19(b) practice. Room #806 was cleaned and boxes removed and then converted into a resident room. Room #807 has had a closure added to it. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the same deficient practice. A complete facility audit was conducted to ensure that all storage rooms were have the potential to be affected by the same deficient practice. A complete facility audit was conducted to ensure that all storage rooms were not self-closing. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. The Executive Director on 8/22/24 on the need for all storage rooms to have closures and locks on them. The Executive Director, Maintenance Director, or designee will complete an entire facility audit once weekly to ensure that all rooms that can be identified and storage rooms are complete with closures. How the corrective action(s) will						PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS_REFERENCED TO THE APPROPRIA)TE	
Findings include: Based on observations and interviews during a tour of the facility with the Executive Director, Maintenance Director and Regional Facilities Support representative on 08/14/24 between 12:20 p.m. and 3:10 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Room #806 which was larger than 50 square feet and contained over 10 boxes of supplies was not self-closing. b) Resident Room #807 which was larger than 50 square feet and contained over 8 boxes of supplies was not self-closing. b) Resident Room #807 which was larger than 50 square feet and contained over 8 boxes of supplies was not self-closing. This finding was acknowledged by the Executive Director agreed the aforementioned rooms were hazardous storage areas, and the doors to the rooms were not self-closing. This finding was acknowledged by the Executive Director, Maintenance Director and Regional Facilities Support representative at the time of observation and again at the exit conference with the Executive Director, Maintenance Director and Regional Facilities Support representative all present. 3.1-19(b) and boxes removed and then converted into a residents naving the potential to be affected by the same deficient practice will be identified and what corrective actions, the same deficient practice. A complete facility audit was conducted to ensure that all storage room doors had closures with not deficient practice noted. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. The Executive Director on 8/2/21/24 to the maintenance Director on 8/2/21/24 to the maintenance Director on 8/2/21/24 to the same deficient practice will be not be affected by the same deficient practice will be identified and what corrective actions, with not deficient practice. A complete great that all storage room doors had closures with not deficient practice does not recur. The Executive Dire	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
assurance program will be put into place. The Executive Director or Maintenance Director will bring		Findings include: Based on observation tour of the facility of the facility of Maintenance Direct Support representant p.m. and 3:10 p.m., following hazardour requirements for properties as a point of the facilities was not seen by Resident Room and supplies was not seen by Resident Rooms. Based on interview Maintenance Direct rooms were hazarded doors to the rooms. This finding was accompany to the company of the facilities Support resident properties.	ons and interviews during a with the Executive Director, tor and Regional Facilities tive on 08/14/24 between 12:20 the corridor doors to the is areas did not meet the otection of a hazardous area: #806 which was larger than 50 tained over 10 boxes of lf-closing. #807 which was larger than 50 tained over 8 boxes of lf-closing. at the time of observation, the tor agreed the aforementioned ous storage areas, and the were not self-closing. cknowledged by the Executive ince Director and Regional epresentative at the time of ain at the exit conference with ctor, Maintenance Director and			practice. Room #806 was clear and boxes removed and then converted into a resident room Room #807 has had a closure added to it. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential be affected by the deficient practice. A complete facility at was conducted to ensure that storage room doors had closul with no deficiencies noted. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur. The Executive Director on 8/22/24 on the need for all stor rooms to have closures and be on them. The Executive Direct Maintenance Director, or desi will complete an entire facility audit once weekly to ensure the all rooms that can be identified storage rooms are complete vertices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p into place. The Executive Director or	the he be ve all to udit all ures into	

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

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	03	COMPL	ETED
		155491	B. WI	NG		08/14/	2024
				CED DET	DDDEGG CHTV OT TO THE TIP COT		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		IEDOVII I E			5TH STREET		
IVIAJES I I	C CARE OF CONN	IEK9VILLE		CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
					any deficiencies to morning		
					meeting so they can be correc	ted	
					in real time. The Executive		
					Director will bring results of the	9	
					audits to monthly QAPI meetir	ig to	
					review with Department Heads	s to	
					determine if additional action of	or	
					auditing needs to be added in		
					order to remain in compliance.		
					Audits will be reviewed by the		
					QAPI Committee until such a t		
					consistent substantial complia		
					has been achieved as determi	ned	
					by the committee.		
IX 0000	NEDA 404						
K 0920 SS=E	NFPA 101						
		ent - Power Cords and					
Bldg. 03	Extens	ant Daway Canda and					
	Extension Cords	ent - Power Cords and					
		patient care vicinity are only					
	used for compone						
	-	ed electrical equipment					
		les that have been					
	, ,	ilified personnel and meet					
		0.2.3.6. Power strips in					
		cinity may not be used for					
	-	personal electronics),					
		n care resident rooms that					
		E. Power strips for PCREE					
		UL 60601-1. Power strips					
		the patient care rooms					
) meet UL 1363. In					
	,	ooms, power strips meet					
	-	s. All power strips are					
		precautions. Extension					
		d as a substitute for fixed					
		re. Extension cords used					
	_	moved immediately upon					
		purpose for which it was					

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Event ID:

AFQM21 Facility ID: 000316

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		03	COMPL	
1554		155491	B. WING			08/14/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			5TH STREET		
MAJESTIC CARE OF CONNERSVILLE				CONNERSVILLE, IN 47331			
	1				T		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCE		DATE
	installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used						
			K 0920		What corrective action will be accomplished for those		09/22/2024
							08/22/2024
	as a substitute for fixed wiring to provide power				residents found to have been		
	equipment with a high current draw.				affected by the deficient		
	NFPA-70/2011, 400.8 state unless specifically				practice.		
	permitted in 400.7 flexible cords and cables shall				No resident was found to have		
	not be used for (1) as a substitute for fixed wiring.				been affected by the deficient		
	This deficient practice could affect up to 2				practice. The power strip was		
	residents in the IT computer room.				immediately removed from service.		
					How other residents having		
	Findings include:				potential to be affected by th		
					same deficient practice will l		
	Based on observations and interviews during a			identified and what corrective		re	
	tour of the facility with the Executive Director,				action(s) will be taken.		
	Maintenance Director and Regional Facilities				All residents have the potential to		
	Support representative on 08/14/24 between 12:20				be affected by the deficient		
	p.m. and 3:10 p.m., in the IT Computer Room a				practice. A facility wide audit was		
	power strip was being used to power a room air				conducted to ensure that no power		
	conditioner (high power draw equipment).				strips were being used improp	-	
					or with a high amp draw in the		
	This finding was acknowledged by the Executive				facility.		
	Director, Maintenance Director and Regional				What measures will be put in	nto	
	Facilities Support representative at the time of			place and what syste			
	observation and again at the exit conference with the Executive Director, Maintenance Director and			changes will be made			
	Regional Facilities Support representative all				ensure that the deficient		
	present.	support representative an			practice does not recur. The Executive Director provide	ed	
	present.				The Executive Director provid education to all Department H		
	3.1-19(b)				on 8/22/24 on proper use of p		
					strips and not using them with		
					anything using a high amp dra		
					The Executive Director and		
					Department Heads will round		
					facility rooms at least 3 times		
					weekly for 3 months to ensure	any l	
					power strips in use will be use		
					properly and not with somethi		

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLI		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1029 E 5TH STREET CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	SUMMAR (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) using a high amp draw. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be point place. The Executive Director or Department Heads will bring and deficiencies to morning meeting so they can be corrected in rectime. The Executive Director or bring results of the audits to monthly QAPI meeting to review the Department Heads to determine if additional action auditing needs to be added in order to remain in compliance Audits will be reviewed by the QAPI Committee until such a consistent substantial compliance by the committee.	the out any ng eal will ew or n e. etime ance	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AFQM21 Facility ID: 000316 If continuation sheet Page 14 of 14