STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING -- B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/14/24 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Emergency Preparedness survey, Majestic Care of Connersville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 166 certified beds. At the time of the survey, the census was 81. Quality Review completed on 08/16/24	E 0000	Please accept this Plan of Correction as our credible allegation of compliance. We respectfully request a desk review in lieu of a post survey revisit.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/14/24 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Life Safety Code survey, Majestic Care of Connersville was found not in compliance with	K 0000	Please accept this Plan of Correction as our credible allegation of compliance. We respectfully request a desk review in lieu of a post survey revisit.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2. The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 81 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 08/16/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of over 4 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 2 residents in 1 smoke compartments. 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 #308 which was larger than 50 square feet and contained over 35 boxes of supplies was not self-closing. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned	K 0321	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to have been affected by the deficient 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 deficient practice. A complete facility audit was conducted to ensure that all storage room doors had closures with no deficiencies noted.	08/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room was a hazardous storage area, and the door to the room did not self-close. 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)		**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 educated the Maintenance 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 as storage rooms are complete with closures. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Executive Director or Maintenance Director will bring any deficiencies to morning meeting so they can be corrected in real time. The Executive Director will bring results of the audits to monthly QAPI meeting to review with Department Heads to determine if additional action or 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 compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 10 residents in one smoke compartment. 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., in the corridor by the Kitchen in the East Building there was a smoke detector located within 3 feet of an air supply where air	K 0341	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to have been affected by the deficient practice. The smoke detector in question was moved to 39 inches of the air source. **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 deficient practice. A complete facility audit was conducted by the Maintenance Director to ensure there were no smoke detectors within 36 inches of an air source	08/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	flow would prevent proper operation of the detector. The MD stated that as ceiling tiles were being replaced that the one containing the smoke detector was installed in the wrong grid. 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)		with no additional deficiencies identified. **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 educated the Maintenance Director on 8/22/24 on importance of not having a smoke detector within 36 inches of an air source. The Maintenance Director or designee will conduct a complete facility audit weekly for 3 months to ensure there are no smoke detectors within 36 inches of an air source. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Executive Director or Maintenance Director will bring any deficiencies to morning meeting so they can be corrected in real time. The Executive Director will bring results of the audits to monthly QAPI meeting to review with Department Heads to determine if additional action or 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 compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms in the West Building was provided with intake combustion air from the outside for rooms containing fuel fired equipment. NFPA 101, Section 19.5.2.2(2) requires any fuel-fired heating device, other than a central heating plant, shall be designed and installed so they shall take air for combustion directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. 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 laundry room had 2 fuel fired dryers with 2 corresponding wall vents to provide air from the outside. The dryer outside vent for the dryer on the left was obstructed by a container full of towels which restricted the outside air from entering the room.	K 0522	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by the deficient practice. The bucket and towels that could have been restricting the air flow were removed from the area. **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 deficient practice. A thick line of red tape was added to the floor as a reminder not to put anything past the line that could possibly restrict air flow or obstruct the vents. **What measures will be put into place and what systematic changes will be made to**	08/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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)		**ensure that the deficient practice does not recur.** The Executive Director or Housekeeping Supervisor educated the laundry and housekeeping staff on 8/22/24 that there could be no obstructions to the vents in the laundry rooms. The Maintenance Director or Housekeeping Supervisor will audit the laundry rooms 5 times weekly for one month and then weekly for 2 months to ensure there are no obstructions to the vents in the laundry rooms. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Executive Director, Maintenance Director, or Housekeeping Supervisor will bring any deficiencies to morning meeting so they can be corrected in real time. The Executive Director will bring results of the audits to monthly QAPI meeting to review with Department Heads to determine if additional action or 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 compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/14/24 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Life Safety Code survey, Majestic Care of Connersville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2. The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 81 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 08/16/24	K 0000	Please accept this Plan of Correction as our credible allegation of compliance. We respectfully request a desk review in lieu of a post survey revisit.	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 03	Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 2 of over 10 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 4 residents in 2 smoke compartments.	K 0321	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to have been affected by the deficient	08/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. Based on interview at the time of observation, the Maintenance 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)		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 deficient practice. A complete facility audit was conducted to ensure that all storage room doors had closures with no deficiencies 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 educated the Maintenance 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 as storage rooms are complete with closures. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Executive Director or Maintenance Director will bring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			any deficiencies to morning meeting so they can be corrected in real time. The Executive Director will bring results of the audits to monthly QAPI meeting to review with Department Heads to determine if additional action or 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 compliance has been achieved as determined by the committee.	
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents in the IT computer room. 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., in the IT Computer Room a power strip was being used to power a room air conditioner (high power draw equipment). 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)	K 0920	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No resident was found to have been affected by the deficient practice. The power strip was immediately removed from service. **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 deficient practice. A facility wide audit was conducted to ensure that no power strips were being used improperly or with a high amp draw in the facility. **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 provided education to all Department Heads on 8/22/24 on proper use of power strips and not using them with anything using a high amp draw. The Executive Director and Department Heads will round facility rooms at least 3 times weekly for 3 months to ensure any power strips in use will be used properly and not with something	08/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			using a high amp draw. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Executive Director or Department Heads will bring any deficiencies to morning meeting so they can be corrected in real time. The Executive Director will bring results of the audits to monthly QAPI meeting to review with Department Heads to determine if additional action or 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 compliance has been achieved as determined by the committee.	