PRINTED: 09/30/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		lì í	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155670	B. W	ING		09/19/	/2022
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
E 0004 SS=C Bldg	conducted by the In accordance with 42 Survey Date: 09/1 Facility Number: 09/1 Facility Number: AIM Number: 200 At this Emergency Care of Newburgh compliance with E Requirements for Participating Provid 483.73. The facility has 10 the survey, the center Quality Review conductor of the Survey of	9/22 011049 155670 0258520 Preparedness survey, Majestic was found in substantial mergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR 4 certified beds. At the time of sus was 84. Impleted on 09/21/22 54(a), 418.113(a), 15(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 920(a), 486.360(a),	E 00	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequest that the plan of correct be considered our allegation of compliance effective 9-30-22 life safety survey completed of 9-19-2022. We respectfully request a paper review and w provide any additional informatic requested.	fic serve s or cility ction of to the n	
	§483.73(a), §483 §485.68(a), §485 §485.920(a), §48 §494.62(a).	6.475(a), §484.102(a), 6.625(a), §485.727(a), 6.360(a), §491.12(a), t comply with all applicable					

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

TITLE (X6) DATE

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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPLETED		
		155670	B. WI	NG		09/19/	2022	
				STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	t .			OSEBUD LANE			
MAJESTI	C CARE OF NEWE	BURGH			JRGH, IN 47630			
W/ WEOT	O ON THE OF THE WE			INLVIDO				
(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 APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Federal, State and	• •						
		uirements. The [facility]						
	•	ablish and maintain a						
	-	nergency preparedness						
		ts the requirements of this						
		gency preparedness						
		ude, but not be limited to,						
	the following elem	ents:						
	` '	an. The [facility] must						
	-	tain an emergency						
		n that must be [reviewed],						
and updated at least every 2 years. The plan								
	must do all of the	following:						
	* [[] = b = = = :t=l= = t	SAGO AF and CALLS at						
		§482.15 and CAHs at						
		ergency Plan. The [hospital						
		nply with all applicable						
		d local emergency						
		uirements. The [hospital or						
	CAH] must develo							
	-	mergency preparedness						
		ts the requirements of this						
	section, utilizing a	n all-hazards approach.						
	* [For LTC Facilitie	os at \$483 73/a\-1						
	_	The LTC facility must						
		tain an emergency						
	-	- ·						
		n that must be reviewed,						
	and updated at lea	ast armuany.						
	* [For ESRD Facili	ities at §494.62(a):]						
	_	The ESRD facility must						
		tain an emergency						
	-	n that must be [evaluated],						
	and updated at lea							
	and updated at lea	asi Cvery 2 years.						
	Based on record rev	view and interview, the facility	E 00	004	It is the practice of this facility	to	09/30/2022	

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failed to develop and maintain an emergency

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review and update the Emergency

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/19/2022
	PROVIDER OR SUPPLIER		STREET 5233 F NEWE	_	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5) LD BE KOPRIATE COMPLETION DATE
	at least annually in	hat was reviewed and updated accordance with 42 CFR ficient practice could affect all		Preparedness Plan at lea annually.	st
	residents in the facilities. Findings include: Based on review of Program and Plan M 9:30 a.m. and 12:00 Operations present, emergency prepared twelve months. The provided was 03/25 time of review, the said the Emergency Manual has not been within the past twelve This finding was resident.	The Emergency Operations Manual on 09/19/22 between D.p.m. with the Director of Plant the facility did provide an dness manual, however, it has and updated during the past e most recent date of review 6/20. Based on interview at the Director of Plant Operations of Operations Program and Plan on reviewed and updated live months. viewed with the Director of dd Executive Director during		The corrective action tal those residents found to affected by the deficient practice includes: There identified residents How other residents that the potential to be affect the same defective practive action will be taken. All residents have potential to be affected by were identified. The Emer Preparedness Plan has be reviewed and updated by committee. What measures will be place and what systemic changes will be made to ensure that the deficient practice does not recur: and maintenance director reeducated on the deficie practice. The ED and QA	t have eled by tice at the ut none rgency een the QA out into The ED were nt
				committee reviewed and the Emergency Prepared as needed and signed completion. How the corrective action	ness plan
				be monitored to ensure the deficient practive will not recur, i.e., what cassurance program will into place:	quality

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	l í	JILDING	ONSTRUCTION	(X3) DATE COMPL 09/19/	LETED
	PROVIDER OR SUPPLIER			5233 R	ADDRESS, CITY, STATE, ZIP COD COSEBUD LANE URGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)		ATE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and proper of the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies and proper of the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies and proper of the emergency (a) of this section, paragraph (a)(1) of the emergency (a) of this section.	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),			An audit will be conducted quarterly with the quality assurance committee to assurant that the Emergency prepared plan is updated with any addichanges or corrections. This review will be documented wisignature sheet and the attent which must include the Executive Director and Director of Maintenance.	ness tional th a dees	

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years.

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	NENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155670	UILDING		COMPL 09/19/	ETED
	OF PROVIDER OR SUPPLIEF STIC CARE OF NEW		5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	and procedures. In develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) communication plesection. The policible reviewed and use "Additional Requires ESRD Facilities: *[For PACE at §46 procedures. The develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) communication plesection. The policies and address manager nonmedical emerginited to: Fire; equilities to: Fire; equilities and procedures and previewed and upded "[For ESRD Facilia and procedures. In develop and implese preparedness polion the emergency (a) of this section, paragraph (a)(1) of this section, paragraph (a)	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually. The ments for PACE and procedures and procedures and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and pencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be atted at least every 2 years. The dialysis facility must				

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ENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPI A. BUILDIN B. WING	E CONSTRUCTION G <u></u>	(X3) DATE SURVEY COMPLETED 09/19/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPE	E COMPLETION
	be reviewed and uyears. These eme not limited to, fire, failures, care-relat supply interruption likely to occur in the area. Based on record revialled to develop an preparedness policipolicies and procedupdated at least ann CFR 483.73(b). The all residents in the failures include: Based on review of Program and Plan May:30 a.m. and 12:00 Operations present, the plan for facility however the policies been reviewed by the recent twelve month of review provided interview at the time Plant Operations sa Program and Plan May procedures has not within the past twel	the Emergency Operations Manual on 09/19/22 between D.p.m. with the Director of Plant there was documentation in policies and procedures, s and procedures have not ne facility within the most ne period. The most recent date was 03/25/20. Based on e of review, the Director of id the Emergency Operations Manual's policies and been reviewed and updated we months. viewed with the Director of d Executive Director during	E 0013	It is the practice of this facilit review and update the Emer Preparedness Plans Policies procedures at least annually The corrective action taken those residents found to be affected by the deficient practice includes: There are identified residents How other residents that he the potential to be affected the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but nowere identified. The Emerge Preparedness Plan has been reviewed and updated by the committee. What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur: The and maintenance director we reeducated on the deficient practice. The ED and QA	gency s and for e re no ave by e none ency n e QA into

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committee reviewed and updated

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	IT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIER			5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					the Emergency Preparednes policy and procedures as need and signed completion.		
					How the corrective action we be monitored to ensure the deficient practic will not recur, i.e., what quates assurance program will be proportional into place:	e lity	
					An audit will be conducted quarterly with the quality assurance committee to assurant that the Emergency prepared plan policy and procedures a updated with any additional changes or corrections. This review will be documented w signature sheet and the atter which must include the Executive Director and Director of Maintenance.	iness re ith a dees	
E 0029 SS=C Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §460: §483.73(c), §483.4 §485.68(c), §485.6 §485.920(c), §486: §494.62(c). (c) The [facility] man emergency pressure of the control of the contro	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					

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	OF CORRECTION	IDENTIFICATION NUMBER 155670	A. BUILDING B. WING			COMPL 09/19/	ETED
	ROVIDER OR SUPPLIER			5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIENT REGULATORY OR REGULATORY OR local laws and must least every 2 yes facilities]. Based on record revisited to develop an preparedness common with Federal, State, and updated at least 42 CFR 483.73(c). affect all occupants affect all occupants. Findings include: Based on review of Program and Plant May 19:30 a.m. and 12:00 Operations present, preparedness plant to emergency prepared to make the time of the replant Operations sa preparedness plant to emergency prepared to been reviewed at twelve months.	st be reviewed and updated ears [annually for LTC view and interview, the facility d maintain an emergency funication plan that complies and local laws was reviewed annually in accordance with This deficient practice could the Emergency Operations Manual on 09/19/22 between op.m. with the Director of Plant the facility has an emergency of develop and maintain an dness communication plan that ral, State, and local laws, been reviewed and updated ve months. The most recent 03/25/20. Based on interview cord review, the Director of id the emergency of develop and maintain an dness communication plan that ral, State, and local laws has and updated within the past viewed with the Director of develop and maintain an dness communication plan that ral, State, and local laws has and updated within the past viewed with the Director of definition of definition of the Executive Director during	EO	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	to ency or no re y ne cy n . A ate	COMPLETION
					reeducated on the deficient practice. The ED and QA committee reviewed and upda the Emergency Preparedness		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED		
		155670	B. Wl	NG		09/19	/2022	
		<u> </u>						
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
NAA IEGTI		DUDOU		5233 ROSEBUD LANE				
MAJEST	IC CARE OF NEW	BURGH		NEWB	URGH, IN 47630			
(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	
					a cover sheet with date that it	was		
					updated and reviewed.			
					How the corrective action wi	II		
					be monitored to			
					ensure the deficient practice	•		
					will not recur, i.e., what quali			
					assurance program will be p	ut		
					into place:			
					An audit will be conducted			
					quarterly with the quality			
					assurance committee to assur	re		
					that the Emergency preparedr	ness		
					plan is completed in its entiret	у.		
					Any additional changes or			
					corrections will be addressed	with		
					updated date. This review will	l be		
					documented with a signature			
					sheet and the attendees which	n		
					must include the Executive			
					Director and Director of			
					Maintenance.			
E 0000	400 740/ 11							
E 0036	403.748(d), 416.5							
SS=C	• •	5(d), 483.475(d), 483.73(d),						
Bldg	484.102(d), 485.6							
	, ,	20(d), 486.360(d),						
	491.12(d), 494.62	• •						
	EP Training and T	_						
	- , , -	6.54(d), §418.113(d),						
		0.84(d), §482.15(d),						
	` ',' -	.475(d), §484.102(d),						
	` ' '	.625(d), §485.727(d),						
	- , , -	6.360(d), §491.12(d),						
	§494.62(d).							

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*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184,

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	ENT OF DEFICIENCIES IN OF CORRECTION	IDENTIFICATION NUMBER 155670	 UILDING	NSTRUCTION	COMPL 09/19/	ETED
	F PROVIDER OR SUPPLIEF		5233 R	ADDRESS, CITY, STATE, ZIP COD DSEBUD LANE JRGH, IN 47630		
(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)	TE	(X5) COMPLETION DATE
	HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testin develop and main preparedness trai that is based on the in paragraph (a) of assessment at pa section, policies at (b) of this section, plan at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The and maintain an etraining and testin the emergency plat of this section, risk (a)(1) of this section at paragraph (b) of communication plates and testing. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing prograte emergency plan sethis section, risk at (a)(1) of this section at paragraph (b) of communication plates communication plates communication plates communication plates	Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at HC/FHQs at §491.12:] (d) ang. The [facility] must tain an emergency ning and testing program are emergency plan set forth of this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years. Se at §483.73(d):] (d) Training LTC facility must develop amergency preparedness g program that is based on an set forth in paragraph (a) assessment at paragraph (b), assessment at paragraph (c) of this sing and testing program and updated at least Season of the section of the et forth in paragraph (a) of the et forth in paragraph (b) of this section, and the et forth in paragraph (c) of this section, and the et forth in paragraph (d) of the et forth in paragraph (e) of this section, and the et forth in paragraph (c) of this section, and the et forth in paragraph (d) of this section, and the et forth in paragraph (e) of this section, and the en at paragraph (c) of this inig and testing program				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155670	B. W	ING		09/19/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		5233 R	OSEBUD LANE		
MAJEST	IC CARE OF NEW	BURGH		NEWBURGH, IN 47630			
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and updated at least every					
	2 years. The ICF/						
		evacuation drills and training					
	at §483.470(i).						
	 *IFor ESRD Facili	ties at §494.62(d):]					
		and orientation. The					
	U U U	st develop and maintain an					
		redness training, testing					
		ation program that is based					
	· ·	plan set forth in paragraph					
	(a) of this section,	risk assessment at					
	paragraph (a)(1)	of this section, policies and					
		agraph (b) of this section,					
		cation plan at paragraph (c)					
		ne training, testing and					
		m must be evaluated and					
	updated at every				It is the property of this facility to		00/00/000
		view and interview, the facility	E 00	036	It is the practice of this facility		09/30/2022
	_	nd maintain an emergency ng and testing program that			review and update the emerge	-	
		ig and testing program that ipdated at least annually in			preparedness plans training a	na	
		CFR 483.73(d). This deficient			testing plan at least annually.		
	practice could affect	. ,			The corrective action taken f	or	
	praetice could affect	van occupants.			those residents found to be	0.	
	Findings include:				affected by the deficient		
					practice includes: There are	no	
	Based on review of	the Emergency Operations			identified residents		
		Manual on 09/19/22 between					
	9:30 a.m. and 12:00	p.m. with the Director of Plant			How other residents that hav	e e	
	Operations present,	there was documentation			the potential to be affected b	у	
		ne facility had an emergency			the same defective practice		
		ng and testing program,			will be identified and what		
	· ·	no documentation to show			corrective action will be		
		d testing program has been			taken. All residents have the		
		ted within the past twelve			potential to be affected but no		
	months. The most recent date of review was				were identified. The Emergend	-	
		n interview at the time of record			Preparedness Plans training a		
		r of Plant Operations said the			testing plan has been reviewe	a	
	emergency prepared	dness training and testing	1		and updated by the QA		l

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Event ID:

D2JD21 Facility ID: 011049

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PRINTED: 09/30/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/19/2022
	ROVIDER OR SUPPLIER		5233 F	ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION en reviewed and updated	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) COMMITTEE.	ON (X5) DE COMPLETION DATE
	within the past twel This finding was re	ve months. viewed with the Director of d Executive Director during		What measures will be purplace and what systemic changes will be made to ensure that the deficient practice does not recur: If and maintenance director is reeducated on the deficient practice. The ED and QA committee reviewed and up the Emergency Prepared in plans training and testing preded and signed complete. How the corrective actions be monitored to ensure the deficient practive will not recur, i.e., what quassurance program will be into place: An audit will be conducted quarterly with the quality assurance committee to as that the Emergency prepar plans training and testing pupdated with any additional changes or corrections. The review will be documented signature sheet and the att which must include the Exercited Director and Director of Maintenance.	The ED Were t pdated ess plan as ption. will tice uality e put ssure pedness plan is l nis with a endees
K 0000					
Bldg. 01	A Life Safety Code	Recertification and State	K 0000	By submitting the enclosed	ı

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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		<u>01</u>	COMPLETED		
		155670	B. WI	ING		09/19	/2022	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NEWBURGH				STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
_					,		1	
(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			CROSS-REFERENCED TO THE APPR		ATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DAII		DATE	
	Licensure Survey was conducted by the Indiana				materials, we are not admitting the			
	_	lth in accordance with 42 CFR	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		truth or accuracy of any spec			
	483.90(a).				findings or allegations. We reserve			
	Survey Date: 09/19/22			the right to contest the findings or allegations as part of any		gs or		
					responses pursuant to our regulatory obligations. The facility			
	Facility Number: 011049							
	Provider Number: 155670							
	AIM Number: 200258520				request that the plan of correction			
					be considered our allegation of			
	At this Life Safety Code survey, Majestic Care of				compliance effective 9-30-22			
	Newburgh was found in compliance with				life safety survey completed on			
	Requirements for Participation in				9-19-2022. We respectfully			
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),			request a paper review and will				
-		ire and the 2012 edition of the			provide any additional inform	ation		
		ection Association (NFPA) 101,			requested.			
•		LSC), Chapter 19, Existing						
	Health Care Occupancies and 410 IAC 16.2.							
	This one story facility was determined to be of							
	Type V (111) construction and was fully							
	sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors,							
	spaces open to the corridors, and all resident							
	spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 104							
	and had a census of 84 at the time of this survey.							
	All areas where res	idents have customary access						
	were sprinklered and all areas providing facility							
	services were sprinklered.							
	Services were sprin	RIOI Cu.						
	Quality Review con	mpleted on 09/21/22						

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