STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION   (X3) DATE SURVE				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE			
E 0000							
Bldg	Preparedness Surve		E 0000				
	Facility Number: 0 Provider Number: AIM Number: 200	155618 145500					
	Majestic Care of Ca with Emergency Pr	ency Preparedness survey, armel was found in compliance eparedness Requirements for caid Participating Providers FR 483.73.					
	The facility has 104 the PSR survey, the	certified beds. At the time of ecensus was 61.					
	Quality Review cor	mpleted on 08/23/22					
K 0000							
Bldg. 01	Code Recertificatio conducted on 06/23	01149	K 0000	Facility requests paper compliance in lieu of on site re on or before 8/30/22 ="" b=""> ="" bthis=""> ="" bthe=""> ="" b=""> ="" b=""> ="" b=""> ="" b = ""> ="" b = ""> ="" b = "">	vist		
	AIM Number: 200	145500		="" b="">			

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DEOX22 Facility ID: 001149 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155618	B. W	ING		08/19/	/2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MAJESTI	C CARE OF CARM	IEL			EL, IN 46032		
(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		LSC IDENTIFYING INFORMATION	4	TAG	DEFICIENCY)		DATE
		fety Code survey, Majestic					
		found not in compliance with					
	Requirements for Pa	-					
		, 42 CFR Subpart 483.90(a),					
	_	re and the 2012 edition of the					
		etion Association (NFPA) 101, SC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
	Health Care Occupa	theres and 410 IAC 10.2.					
	This two-story facil	ity was determined to be of					
	_	ruction and fully sprinklered.					
		re alarm system with smoke					
	-	ridors, spaces open to the					
		wired smoke detectors in all					
	resident rooms. The	healthcare portion of the					
	facility has a capaci	ty of 104 and had a census of					
	61 at the time of this	s PSR visit.					
		dents have customary access					
	_	d all areas providing facility					
	services were sprink	klered.					
	Quality Review con	npleted on 08/23/22					
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting of	corridor openings in other					
	than required encl	osures of vertical openings,					
	exits, or hazardous	s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	•	g fire for at least 20					
		fully sprinklered smoke					
	-	only required to resist the					
	_	. Corridor doors and doors					
	to rooms containin	_					
		rials have positive latching					
		atches are prohibited by					
	CMS regulation. T	hese requirements do not					

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet Page 2 of 12

		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			
		155618	B. WING		08/19/2022	
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	•	
MAJEST	IC CARE OF CARM	/IEL	12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	apply to auxiliary	spaces that do not contain				
	flammable or com	bustible material.				
	Clearance betwee	en bottom of door and floor				
	covering is not ex	ceeding 1 inch. Powered				
	doors complying v	vith 7.2.1.9 are permissible				
	if provided with a	device capable of keeping				
		hen a force of 5 lbf is				
		no impediment to the				
	_	rs. Hold open devices that				
		door is pushed or pulled are				
	•	ed protective plates of				
	unlimited height are permitted. Dutch doors					
meeting 19.3.6.3.6 are permitted. Door						
		beled and made of steel or				
		compliance with 8.3,				
	unless the smoke					
		fire window assemblies are				
	-	n sprinklered compartments ctions in area or fire				
		s or frames in window				
	assemblies.	S OF ITAILIES III WILIDOW				
	assemblies.					
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,				
	483, and 485					
	Show in REMARK	(S details of doors such as				
	fire protection ration	ngs, automatics closing				
	devices, etc.					
	Based on observation	on and interview, the facility	K 0363	K 363 CORRIDOR - DOORS	08/30/2022	
		corridor doors had no		Based on observation and		
	_	ing and latching into the door		interview, the facility failed to		
		sist the passage of smoke.		ensure all corridor doors had	no	
	This deficient pract	ice could affect 3 staff.		impediment to closing and		
				latching into the door frame a	nd	
	Findings include:			would resist the passage of		
	<b>.</b>			smoke. This deficient practice	)	
		tour and interview with the		could affect 3 staff.		
		on 08/19/22 between 9:45 a.m.				
		Elevator Room corridor door,		Findings include:		
		f-closing device failed to latch				
	positively into its de	oor frame. The Executive		Based on a facility tour and	1	

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155618	B. W	ING		08/19/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			N PENNSYLVANIA ST		
MAJESTI	IC CARE OF CARM	ΛΕΙ			EL, IN 46032		
IVIAULUII	ONINE OF OARIN			O/AI (IVIE	, 11 70002		
(X4) ID	SUMMARY	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		hought this repair had been			interview with the Executive		
	-	nowledged the condition was			Director on 08/19/22 between	9:45	
	still present.				a.m. and 11:45 a.m., the Eleva		
	-	knowledged by the Executive			Room corridor door, equipped		
		of discovery and again at the			a self-closing device failed to l		
		h the Executive Director			positively into its door frame.	Γhe	
	present.				Executive Director stated he		
					thought this repair had been		
		s originally cited on 06/23/22.			completed, but acknowledged	the	
	•	o implement a systemic plan of			condition was still present.		
	correction to prever	nt recurrence.					
					What corrective action(s) wi	II	
	3.1-19(b)				be accomplished for those		
					residents found to have been	า	
					affected by this practice?		
					The Executive Director		
					oversaw the installation of a		
					new door closer on the		
					Elevator Room corridor room	n	
					by CIH contractors on		
					8/23/2022. Installation		
					included, but was not limite		
					to installation of a new Close	er,	
					hooked up the foot and		
					adjusted the speeds, remove		
					the top 2 hinges and remove		
					the wire behind the hinges to		
					get a better gap on the strike		
					side. Reinstalled the hinges.		
					The installation (i)		
					The installation of the new clo		
					on the Door to the Elevator Ro		
					and adjustments was complet		
					on 8/23/2022 and the door no		
					closes and latches securely or	n its	
					own. REPORT FROM CIH		
					ATTACHED.		
			1		I		I

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet Page 4 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155618	A. BUILDING B. WING	01	COMPLETED 08/19/2022
	ROVIDER OR SUPPLIER		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				How will you identify all otheresidents having the potentiato be affected by the same deficient practice and what corrective action will be taked.  All residents, visitors, and staff have the potential to be affected by the alleged deficient practice.  The Executive Director and Maintenance staff reviewed doors in the facility to ensure that they latch effectively to door frames and all doors wis self closers do so automatically.  What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?  The installation of the new closer on the Door to the Elevator Room and adjustments was completed 8/23/2022 and the door now closes and latches securely its own. REPORT FROM CITATCHED.	all en? all e the ith on
				All Maintenance staff were provided in-service training	on

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet

Page 5 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 01 COMPLETED  B. WING 08/19/2022			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST	
MAJESTI	C CARE OF CARM	IEL .		EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Corridor – Doors specifically focusing on the requirement that corridor doors must late have door knobs, and close automatically if there is a closer.  The Executive Director/designee will	i
				complete a Life Safety CQI audit tool daily for seven da weekly for seven weeks; monthly thereafter to monito compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will developed to assure compliance. Audit will also	be
				completed at the conclusion construction in addition to to the CQI schedule set forth above.  How will the corrective action(s) be monitored to ensure the deficient practice will not recur?	o of he e.
				The Executive Director/designee will comple Life Safety CQI audit tool dail seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintai for two consecutive quarters. threshold of 100% is not achie	y for ned If

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet

Page 6 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155618	A. BUILDING  B. WING	01	COMPLETED 08/19/2022
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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)	DATE
				an action plan will be developed assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule is forth above.  The Elevator Room Door has added as a weekly task to the TELS system to ensure that the door is given additional oversign weekly moving forward.  The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings.  The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections.  The Maintenance Director and Administrator a responsible for these results	et been e ght  v ed

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet

Page 7 of 12

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyg another is in accord Transfilling of High Oxygen Used for I any gas from one prohibited in patie to liquid oxygen containers over 50 under 11.5.2.3.1 ( liquid oxygen containers under 1 11.5.2.2 (NFPA 98 Based on observation failed to ensure 1 of were separated from room that is protect fire-resistive constrainers.  Findings include:  Based on a facility to Executive Director and 11:45 a.m., the Transfilling room, election hinges, failed to clothe door frame. The the door was schedulago, and he wasn't set.	1.5.2.3.2 (NFPA 99).  2)  2)  2)  3)  3)  4)  5)  6)  6)  6)  6)  7)  6)  7)  8)  8)  9)  9)  1.5.2.3.2 (NFPA 99).  9)  9)  1.5.2.3.2 (NFPA 99).  9)  1.5.2.3 (NFPA 99).  9)  1.	K 0927	K 927 GAS EQUIPMENT – TRANSFILLING CYLINDERS Based on observation and interview, the facility failed to ensure that 1 of 1 oxygen transfilling rooms was separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction.  Findings include:  Based on a facility tour and interview with the Executive Director on 08/19/22 between a.m. and 11:45 a.m., the corridor to the Oxygen Transfilling room, equipped with self-closinges, failed to close, and late positively into the door frame. Executive Director stated that door was scheduled to be replaced a few days ago, and	9:45 dor g ing ich The the

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet Page 8 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  08/19/2022			COMPLETED
	PROVIDER OR SUPPLIE			12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION as originally cited on 06/23/22. to implement a systemic plan of		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  Wasn't sure why it hadn't bee done.  What corrective action(s) we be accomplished for those residents found to have bee affected by this practice?  The Executive Director oversaw the installation of a new door to the Oxygen Transfilling Room by CIH contractors on 8/23/2022. Installation included, but we not limited to a new door, closer, lockset, hinges, swuthe new door, hooked up the door closer foot and adjusted the speeds.	DATE  DATE  DATE  n  vill  en  or  a  ling  ee ed
					The door installation to the Oxygen Transfilling Room v completed on 8/23/2022 and door closes automatically a latches positively to the door frame ensuring that the oxy transfilling room is separate from other areas in the facil in a room that is protected v a one hour fire-resistive construction.  How will you identify all oth residents having the potent to be affected by the same deficient practice and what corrective action will be tak  All residents, visitors, and staff have the potential	vas I the Ind

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet

Page 9 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

	F OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 08/19/2022	
	ROVIDER OR SUPPLIEI C CARE OF CARM		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE	
				be affected by the alleged deficient practice.		
				The Executive Director oversaw the installation of new door to the Oxygen Transfilling Room by CIH contractors on 8/23/2022. Installation included, but wont limited to a new door, closer, lockset, hinges, swithe new door, hooked up the door closer foot and adjust the speeds.  The door installation to the	vas ung ne ted	
				Oxygen Transfilling Room completed on 8/23/2022 and door closes automatically a latches positively to the do frame ensuring that the oxy transfilling room is separat from other areas in the faci in a room that is protected a one hour fire-resistive construction. REPORT FROCIH ATTACHED	d the and oor ygen ed ility with	
				What measures will be put into place or what systemic changes you will make to ensure the deficient practic will not recur?  The Oxygen Transfill Room door installation was completed on 8/23/2022. Installation included, but wont limited to a new door, closer, lockset, hinges, swe	ce ing s	

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

Event ID:

 $DEOX22 \quad \ \ Facility ID: \quad \ 001149$ 

If continuation sheet

Page 10 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í		ONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155618	A. BUILDING 01 COMPLETED  B. WING 08/19/2022				
		100010		_	A DEDECC CUTY OF THE TUD COD	00/10/2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST		
MAJEST	IC CARE OF CAR	MEL			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ie	PLETION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION		TAG			ATE
					the new door, hooked up the door closer foot and adjuste		
					the speeds. REPORT FROM	<b>4</b>	
					CIH ATTACHED.		
					· The Executive		
					Director/designee will		
					complete Life Safety CQI aud tool daily for seven days;	lit	
					weekly for seven weeks;		
					monthly thereafter to monito	r	
					compliance until compliance		
					has been maintained for two		
					consecutive quarters. If		
					threshold of 100% is not	ha	
					achieved an action plan will developed to assure	be	
					compliance. Audit will also	oe l	
					completed at the conclusion		
					construction in addition to the	ne	
					CQI schedule set forth above	<b>)</b> .	
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice will not recur?		
					Will Hot recur:		
					The Executive		
					Director/designee will		
					complete a Life Safety CQI audit tool daily for seven day	,e.	
					weekly for seven weeks;	,	
					monthly thereafter to monito	r	
					compliance until compliance		
					has been maintained for two		
					consecutive quarters. If		
					threshold of 100% is not		
					achieved an action plan will	be	
					developed to assure	ne	

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

Event ID:

DEOX22 Facility ID: 001149

If continuation sheet

Page 11 of 12

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) M		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	01	COMPLETED	
		155618	B. WING 08/19/2022			2022	
			<del></del>	CTDEET :	DDDEGG OUTV OT ATT THE COP		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	IO OADE OF OADA	45.			N PENNSYLVANIA ST		
MAJEST	IC CARE OF CARM	1EL		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	_	ID	DDAVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					completed at the conclusion	of	
					construction in addition to the		
					CQI schedule set forth above		
					Our serieudie set fortif above		
					- The Oxygen Transfillin	a	
					Room has been added as a	9	
					weekly task to the TELS syst	em	
					to ensure that the door is giv		
					additional oversight weekly	<b>U</b> 11	
					moving forward.		
					moving forward.		
					· The Maintenance		
					Director/designee and		
					Executive Director will review	v	
					the Life Safety CQI and any	•	
					issues identified through the		
					_		
					CQI process will be addresse	<del>2</del> u	
					immediately via corrective		
					action plan. Maintenance		
					Director/designee will also		
					review the results with the		
					Safety Committee at their		
					monthly meetings.		
					The Cofety Committee		
					The Safety Committee		
					will monitor results of the		
					inspections and report to the	;	
					Continuous Quality		
					Improvements Committee on	l	
					their results from the		
					inspections.		
					The Med 4		
					The Maintenance		
					Director and Administrator a		
					responsible for these results		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DEOX22 Facility ID: 001149 If continuation sheet Page 12 of 12