STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	ILDING		COMPL	
		155665	B. WI	NG		07/08/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF NORT	H VERNON	701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg	conducted by the In	paredness Survey was diana Department of Health in	E 00	000	The creation and submission this Plan of Correction does	not	
	accordance with 42 Survey Date: 07/08			constitute an admission provider of any conclus forth in the statement of deficiencies, or any viole		set	
	Facility Number: 0				regulation.		
	Provider Number:				This provider respectfully		
	AIM Number: 2002	232210			requests that State Report P		
K 0000	Care of North Vern- with Emergency Pro Medicare and Medi- and Suppliers, 42 C	certified beds. At the time of us was 101.			of Correction be considered the Letter of Credible Allegation. This provider alleges compliance as of July 18, 2024. The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.		
10000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/08 Facility Number: 0 Provider Number: AIM Number: 2000 At this Life Safety 0	10996 155665	K 00	000	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or any violation regulation. This provider respectfully requests that State Report P of Correction be considered Letter of Credible Allegation. This provider alleges compliance as of July 18, 20	not this set n of lan the	

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

TITLE

(X6) DATE

Phil Ford Executive Director 07/24/2024

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: J8M521 Facility ID: 010996 If continuation sheet Page 1 of 21

CENTERS FUR	WIEDICARE & WIEDIC				ONID NO. 0936-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155665	B. WING		07/08/2024		
		<u> </u>	 _				
NAME OF F	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD			
	IO OADE OE :: 0==	SULVEDNON.	701 HENRY STREET				
MAJEST	IC CARE OF NORT	H VERNON	NORTH	H VERNON, IN 47265			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	TION (X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Requirements for P	articipation in		The facility respectfully			
	Medicare/Medicaid	l, 42 CFR Subpart 483.90(a),		requests a desk review for thi	s		
	Life Safety from Fi	re and the 2012 edition of the		Plan of Correction relative to			
	· ·	ction Association (NFPA) 101,		the low scope and severity of			
		LSC), Chapter 19, Existing		this survey in lieu of a			
		ancies and 410 IAC 16.2.		post-survey revisit.			
	1						
	This one story facil	ity was determined to be of					
	1	ruction and fully sprinkled.					
		re alarm system with smoke					
	I -	ridors, spaces open to the					
		wired smoke detectors in all					
		oms. The facility has a					
		had a census of 101 at the					
	time of this visit.	inde a consus of 101 at the					
1	time of time visit.						
	All areas where res	idents have customary access					
		all areas providing facility					
	services were sprin						
	services were sprin	Ricu.					
	Quality Review cor	mpleted on 07/15/24					
K 0200	NFPA 101						
SS=E		Requirements - Other					
Bldg. 01		Requirements - Other					
		RKS section any LSC					
		19.2 Means of Egress					
		are not addressed by the					
		out are deficient. This					
		with the applicable Life					
		FPA standard citation,					
	1	d on Form CMS-2567.					
	18.2, 19.2						
		ation and interview, the facility	K 0200	What corrective action(s) will be	07/28/2024		
		f 1 closet doors in the beauty	K 0200	accomplished for those residen			
		with a locking mechanism		found to have been affected by			
		be unlocked from the inside in		deficient practice?			
	the case of fire or o			denoient practice:			
		SC 7.1.10.1. This deficient		1 1. The slide lock on the			
		et staff and at least 2 residents		beauty shop closet door has be	en		
	Practice could affect	a starr und ut roust 2 rosidonts	1	I poduty shop dioset door has be	OII		

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(Y2) M	III TIDI E CC	ONSTRUCTION	(X3) DATE	SLIDVEA	
						,	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED	
		155665	B. W	ING		07/08/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
			701 HENRY STREET				
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	I VERNON, IN 47265		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	in the beauty shop a	area.			removed.		
					2 2. The slide locks on the		
	Findings include:			Guest Bathroom doors have been			
					removed.		
		on on 07/08/2024 between 2:45					
	PM and 4:45 PM during a tour of the facility with						
	the Maintenance Director, the closet in the beauty				How other residents having th		
		with a key lock which was			potential to be affected by the		
	•	d from the inside. Based on			same practice will be identifie		
		e of observation, the			and what corrective action(s)	will	
		tor agreed the door had a key			be taken?		
		e to be opened from the inside.					
	The Maintenance Director stated the beautician				All Guests and Staff in the fac	ility	
	uses the closet to st	ore her items when in the			could be affected.		
	beauty shop.						
					What measures will be put int	0	
	_	viewed with the Executive		place and what systemic changes			
	Director and Mainte	enance Director during the exit			will be made to ensure that th	е	
	conference.				deficient practice does not red	cur?	
	3.1-19(b)				1 1. Inspection for inapprop	vriata	
	3.1-17(0)				locking mechanisms has been		
	2 Raced on observe	ation and interview, the facility			added to the Maintenance	ı	
		f 2 bathrooms near the			Supervisor's ongoing inspecti	on	
		s office which were able to be			schedule.	OH	
		inside in case of fire or other			2 2. Ongoing review by the	FD	
		readily accessible in accordance			or his designee, will be perfor		
	_	This deficient practice could			to ensure scheduled inspection		
		residents, and visitors			are being completed and follo		
	occupying the bath					weu	
	occupying the bath	iooms.			up on as planned.		
	Findings include:						
					How the corrective action(s) v	vill be	
	Based on observation	on on 07/08/2024 between 2:45			monitored to ensure the defici		
	and 4:45 PM during	g a tour of the facility with the			practice will not recur, i.e., wh	at	
	Maintenance Director, the 2 bathrooms near the				quality assurance program wi		
	Executive Director	's office were observed to have			put into place?		
	a key lock and a sli	de lock on the doors. The slide			['		
		om doors do not allow the			1 1. For Quality Assurance	, the	
		from the outside in the event			Maintenance Supervisor, or h		

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BUILDING B. WING	01	COMPLETED 07/08/2024
	ROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the observation, the he could hit the door door if needed. At the Executive Direct use these bathrooms visitors only. This finding was revenue.	Maintenance Director stated r with his body to open the ne time of the exit conference, tor stated residents are not to as they are for staff and viewed with the Executive mance Director during the exit		designee, will review for inappropriate locking mechani 5 days a week for 2 weeks, the weekly for 6 weeks, then mon for an additional 4 months. 2 2. Findings will be reported the ED and the QA Committee 6 months and will continue un 100% compliance has been achieved. By what date the systemic changes for each deficiency we be completed? 7.28.24	en thly d to e for til
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-ado not exceed 48 if the door.	reprotected by a fire pur fire resistance rating rated doors) or an anguishing system in areas shall be separated by smoke resisting rating in accordance with 8.4. Felosing or and permitted to have pplied protective plates that anches from the bottom of			

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

Page 4 of 21

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPL	
		155665	B. Wl	NG		07/08	/2024
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	Separation a. Boiler and Fue b. Laundries (larg c. Repair, Mainte d. Soiled Linen R gallons) e. Trash Collectic (exceeding 64 ga f. Combustible St (over 50 square f g. Laboratories (if Hazard - see K32 Based on observati failed to ensure the Housekeeping 4 wh size, was provided which would cause close and latch into practice could affer in this smoke comp observation, 2 staff housekeeping area contains offices, th the Pavilion. Findings include: Based on observati 2:45 PM and 4:45 i Director, the doors 4 were not equippe mechanisms. Hous cleaning rags, liner freestanding shelve Housekeeping 4 co boxes, decorations alcohol based chen freestanding shelve and other housekeep	N/A I-Fired Heater Rooms for than 100 square feet) for nance, and Paint Shops for sooms (exceeding 64 In Rooms Illons) for age Rooms/Spaces for classified as Severe for classified as Severe for classified as Severe for square feet in with a self-closing device for the door to automatically for the door frame. This deficient for staff, visitors, and residents for members were located in the for members were located in the This smoke compartment also for the kitchen, the Peony Cafe, and for soon 07/08/2024 between for the Maintenance for housekeeping rooms 3 and	K 0		What corrective action(s) will accomplished for those reside found to have been affected by deficient practice? The identified housekeeping on now have self-closing mechaninstalled. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) be taken? All residents and staff in the facility could be affected. What measures will be put integrated place and what systemic chains will be made to ensure that the deficient practice does not reconstructed. 1 Inspection for appropriate locking mechanisms has been added to the Maintenance Supervisor's ongoing inspection.	ents by the doors nisms ne e do will to nges ne cur? riate n	07/28/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIER		701 HI	CADDRESS, CITY, STATE, ZIP COD ENRY STREET TH VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	interview at the time Maintenance Direct significant amount of aforementioned loca mechanisms on the This finding was re-	e of observation, the or agreed there was a of combustible materials in the ations with no self-closing doors. viewed with the Executive aintenance Director at the exit	TAG	schedule. 2 2. Ongoing review by the or his designee, will be perfoto ensure scheduled inspectiare being completed and folloup on as planned. How the corrective action(s) monitored to ensure the deficiencities will not recur, i.e., with quality assurance program with which will be proposed to the Maintenance Supervisor, designee, will review for appropriate locking mechanistic days a week for 2 weeks, then weekly for 6 weeks, then mo for an additional 4 months. 2 2. Findings will be reported the ED and the QA Committee 6 months and will continue used 100% compliance has been achieved. By what date the systemic changes for each deficiency be completed? 7.28.24	rmed ons owed will be sient nat rill be e, or his sms 5 en nthly red to ee for ntil
K 0353 SS=C Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in		De completeu: 7.20.24	

07/26/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155665 B. WING 07/08/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and K 0353 What corrective action(s) will be 07/28/2024 interview; the facility failed to document sprinkler accomplished for those residents system inspections in accordance with NFPA 25. found to have been affected by the NFPA 25, Standard for the Inspection, Testing, deficient practice? and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states The monthly sprinkler valve and gauges on wet pipe sprinkler systems shall be gauge inspections documentation inspected monthly to ensure that they are in good was discovered following the condition and that normal water supply pressure survey visit. The documentation is being maintained. Section 5.1.2 states valves will be filed in a manner that and fire department connections shall be allows for effective retrieval. inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 4.3.1 states How other residents having the records shall be made for all inspections, tests, potential to be affected by the and maintenance of the system and its same practice will be identified components and shall be made available to the and what corrective action(s) will authority having jurisdiction upon request. This be taken? deficient practice could affect all residents and staff in the facility. All residents and staff in the facility could be affected. Findings include: What measures will be put into

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

Based on record review with the Maintenance

Director on 07/08/2024 between 10:45 AM and

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

place and what systemic changes

will be made to ensure that the

Page 7 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	ΓIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
		155665	B. WING	i		07/08/	2024
		<u> </u>	5	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			NRY STREET		
MAJEST	IC CARE OF NORT	H VERNON	1	NORTH	VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	7	ΓAG	DEFICIENCY)		DATE
	•	entation was able to be			deficient practice does not rec	ur?	
		monthly valve and gauge					
	_	me of the survey. Based on			1 1. More effective filing of		
		e of record review, the			monthly sprinkler valve and ga	uge	
		or stated he was unable to			inspection documentation has		
	located the monthly				been added to the Maintenand		
		e physical paperwork or on			Supervisor's ongoing inspection	on	
		to locate the quarterly sprinkler			follow-up.		
	system documents of	completed by SafeCare.			2 2. Ongoing review by the		
	TEN : C' 1'				or his designee, will be perform		
		viewed with the Executive enance Director at the exit			to ensure scheduled inspection		
		enance Director at the exit			are being completed and follow	wed	
	conference.				up on as planned.		
	2.1.10/1-)						
	3.1-19(b)					:II I	
					How the corrective action(s) w		
					monitored to ensure the deficie		
					practice will not recur, i.e., who		
					quality assurance program will	be	
					put into place?		
					1 1. For Quality Assurance	,	
					the Maintenance Supervisor, o		
					designee, will review for month	nly	
					sprinkler valve and gauge		
					inspections documentation 5 c	lays	
					a week for 2 weeks, then weel	-	
					for 6 weeks, then monthly for a	-	
					additional 4 months.		
					2 2. Findings will be reporte	d to	
					the ED and the QA Committee		
					6 months and will continue unt	til	
					100% compliance has been		
					achieved.		
					By what date the systemic		
					changes for each deficiency w	ill	
					be completed? 7.28.24		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J8M521 Facility ID: 010996 If continuation sheet Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET I VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extir Portable Fire Extir				
Blag. 01	Portable fire exting installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5.	guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10			
	Based on observati failed to inspect 1 o maintenance office, D hall mechanical r the water softener reextinguishers in the NFPA 10, Standard Section 7.2.1.2 state inspected either mare electronic device / s intervals. Section 7. or electronic monitorinclude a check of a (1) Location in desi (2) No obstruction t (3) Pressure gauge 1 operable range or per (4) Fullness determined to inspect the section of the s	on and interview, the facility f 1 fire extinguishers in the 1 of 1 fire extinguishers in the com, 1 of 1 fire extinguishers in com, and 1 of 1 fire washer room each month. for Portable Fire Extinguishers, es fire extinguishers shall be mually or by means of an system at a minimum of 30-day 2.2 states periodic inspection oring of fire extinguishers shall at least the following items: gnated place o access or visibility reading or indicator in the osition ined by weighing or hefting for extinguishers,	K 0355	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? The four identified fire extinguishers have been chect and judged as functional and ready for service. Their tags he been labeled as such. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) who be taken? All residents and staff in the	nts y the ked nave e
	cartridge-operated et (5) Condition of tire nozzle for wheeled (6) Indicator for nor using push-to-test p Section 7.2.4.1 state inspections shall ke extinguishers inspective accordance at least monticonducted, the date performed and the i	extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers nrechargeable extinguishers ressure indicators. es personnel making manual ep records of all fire cted, including those found to ection. Section 7.2.4.3 requires hly manual inspections are the manual inspection was		facility could be affected. What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not reconstruction. 1. Additional identifiers indicating certain extinguisher locations have been added. 2. A facility floor plan has been utilized to identify each location of the facility's fire	ges e ur?

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

Event ID:

J8M521 Faci

Facility ID: 010996

If continuation sheet

Page 9 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		r ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2024		
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD IRY STREET		
MAJEST	IC CARE OF NORT	H VERNON			VERNON, IN 47265		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PREF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		λΤΕ.	(X5) COMPLETION
TAG	Section 7.2.4.4 requare conducted, reconshall be kept on a tal extinguisher, on an maintained on file, section 7.2.4.5 required demonstrate that at inspections have be practice could affect. Based on observation on 07/08/2024 betwith emaintenance office, softener room, and as being checked for interview at the time Maintenance Direct extinguishers in the were not checked for sign the tag for June This finding was reduced by the maintenance office, softener room, and as being checked for interview at the time Maintenance Direct extinguishers in the were not checked for sign the tag for June This finding was reduced by the maintenance Director and Maintenance Dire	circs where manual inspections and for manual inspections are for manual inspection and the manual inspection are formed. This deficient at at least 5 staff in these areas. In during a tour of the facility freen 2:45 PM and 4:45 PM with frector, the monthly inspection are guishers located in the D hall mechanical room, water washer room were not marked are June 2024. Based on the of observation, the for agreed the fire afforementioned locations for June and asked if he could at the time of observation. In a series of the fire afforement in the executive enance Director at the exit	TA		extinguishers to assist in inspection completion. 3 3. Ongoing review by the or his designee, will be perfort to ensure scheduled inspection are being completed and follow up on as planned. How the corrective action(s) we monitored to ensure the deficing practice will not recur, i.e., who quality assurance program with put into place? 1 1. For Quality Assurance the Maintenance Supervisor, and designee, will review the location of each fire extinguisher 5 day week for 2 weeks, then week! 6 weeks, then monthly for an additional 4 months. 2 2. Findings will be reported the ED and the QA Committee 6 months and will continue und 100% compliance has been achieved. By what date the systemic changes for each deficiency we be completed? 7.28.24	med ins wed vill be ent at l be c, or his cion /s a y for ed to e for til	DATE
K 0363 SS=B Bldg. 01	than required encl exits, or hazardou	corridor openings in other osures of vertical openings, s areas resist the passage					

PRINTED: 07/26/2024

CENTERS FO		OMB NO. 0938-039				
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION O1	(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIE		701	ET ADDRESS, CITY, STATE, ZIP COD HENRY STREET RTH VERNON, IN 47265		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE COPRIATE	(X5) COMPLETION DATE
	solid-bonded corcapable of resisti minutes. Doors in compartments are passage of smoke to rooms containing combustible materials and the ardware. Roller CMS regulation. Apply to auxiliary flammable or concomplying if provided with a the doors complying if provided with a the door closed wapplied. There is closing of the door release when the permitted. Nonrain unlimited height a meeting 19.3.6.3 frames shall be lated their materials in unless the smoke sprinklered. Fixed allowed per 8.3. If there are no restrict resistance of glass assemblies.	e wood or other material ng fire for at least 20 n fully sprinklered smoke e only required to resist the e. Corridor doors and doors ing flammable or erials have positive latching latches are prohibited by These requirements do not spaces that do not contain nbustible material. en bottom of door and floor eceding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is is no impediment to the ors. Hold open devices that e door is pushed or pulled are ted protective plates of are permitted. Dutch doors a compliance with 8.3,	K 0363	What corrective action(s)	will be	07/28/2024

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

failed to ensure 1 of 1 resident sleeping room

doors in room A107 could close completely and

latch into the door frame. This deficient practice

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

accomplished for those residents

deficient practice?

found to have been affected by the

Page 11 of 21

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155665	B. W	ING	_	07/08	/2024
NAME OF P	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
					NRY STREET		
MAJEST	IC CARE OF NOR	IH VERNON		NORTE	H VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF C			(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	could affect 2 residents, staff, and visitors to the room.				The one resident door that did	l not	
	100111.				latch securely has been repair		
	Findings include:				and is functioning as it should		
	i mamga meraaci			and is functioning as it should.		•	
	Based on observation	on during a tour of the facility					
	on 07/08/2024 between 2:45 and 4:45 PM with the				How other residents having th	е	
		tor, the door to room A 107			potential to be affected by the		
		into the frame. Based on			same practice will be identified		
		ne of the observation, the			and what corrective action(s)	Will	
	A107 was unable to	tor agreed the door to room			be taken?		
	71107 was unable to	s laten.			All residents and staff in the		
	This finding was re	eviewed with the Executive			facility could be affected.		
		enance Director at the exit					
	conference.				What measures will be put into	0	
					place and what systemic char	-	
	3.1-19(b)				will be made to ensure that the		
					deficient practice does not rec	:ur?	
					1 1. Inspection of each		
					resident doors 5 days a week	for 2	
					weeks, then weekly for 6 wee		
					then monthly for an additional		
					months has been added to the		
					Maintenance Supervisor's, or	his	
					designee's, responsibilities to		
					ensure proper closure.		
					1 2. Ongoing review by the		
					or his designee, will be perfore		
					to ensure scheduled inspection		
					are being completed and follo up on as planned.	wed	
					up on as planified.		
					How the corrective action(s) w	vill be	
					monitored to ensure the defici		
					practice will not recur, i.e., wh		
					quality assurance program wil	l be	
	İ				put into place?		I

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì '		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BUILD B. WING	DING	01	COMPL 07/08/	
		100000				07/06/	2U2 4
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
MAJESTI	IC CARE OF NORT	H VERNON	NORTH VERNON, IN 47265				
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
K 0511 SS=B Bldg. 01	complies with NFF Code, electrical with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 1 of central nurses' static 2011 Edition. Articl (Cover Plates), requibe installed so as to and seat against the deficient practice complete.	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0511		2 1. For Quality Assurance, Maintenance Supervisor, or hi designee, will review the proper closure of each resident's dood days a week for 2 weeks, then weekly for 6 weeks, then montfor an additional 4 months. 3 2. Findings will be reported the ED and the QA Committee 6 months and will continue untanged to the end of the systemic changes for each deficiency with the completed? 7.28.24 What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? This one electrical box cover vinstalled and corrected by the Maintenance Assistant at the tof observation.	s er r 5 i thly d to e for till rill vill vas time	07/28/2024

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

Page 13 of 21

07/26/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155665 B. WING 07/08/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE potential to be affected by the Based on observation during a tour of the facility same practice will be identified on 07/08/2024 between 2:45 PM and 4:45 PM with and what corrective action(s) will the Executive Director, the electrical box at the be taken? central nurses' station did not have a coverplate attached. Based on interview at the time of All residents and staff in the observation, the Maintenance Director stated his facility could be affected. assistant had been working on this earlier in the day. This was corrected by the Maintenance What measures will be put into Assistant at the time of observation. place and what systemic changes will be made to ensure that the This finding was reviewed with the Executive deficient practice does not recur? Director and the Maintenance Director at the exit conference. 1. Inspection of properly installed electrical cover plates 5 3.1-19(b) days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months has been added to the Maintenance Supervisor's ongoing inspection schedule. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review for properly installed electrical cover plates 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until

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

Event ID:

J8M521

Facility ID: 010996

100% compliance has been

If continuation sheet

Page 14 of 21

						PRIN	TED:	07/26/2024	
EPARTMENT OF HEALTH AND HUMAN SERVICES								FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 09	938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		<i>I</i>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED				
		155665	B. WI	NG		07/08/	2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON				701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265				
(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 APPROPRIATE		COMP	LETION	
TAG	DECLII ATODV OD	I SC IDENTIEVING INFORMATION	l	TAG	DEFICIENCY)		D/	\TE	

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
			achieved.	
			By what date the systemic	
			changes for each deficiency will	
			be completed? 7.28.24	
C 0712	NFPA 101			
SS=F	Fire Drills			
Bldg. 01	Fire Drills			
	Fire drills include the transmission of a fire			
	alarm signal and simulation of emergency fire			
	conditions. Fire drills are held at expected			
	and unexpected times under varying			
	conditions, at least quarterly on each shift.			
	The staff is familiar with procedures and is			
	aware that drills are part of established routine. Where drills are conducted between			
	9:00 PM and 6:00 AM, a coded			
	announcement may be used instead of			
	audible alarms.			
	19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility	K 0712	What corrective action(s) will be	07/28/2024
	failed to conduct 3rd shift quarterly fire drills for 1		accomplished for those residents	
	of 4 quarters. LSC 19.7.1.6 requires drills to be		found to have been affected by the	
	conducted quarterly on each shift under varied		deficient practice?	
	conditions. This deficient practice affects all staff and residents.		1 1. An additional fire drill for	
	and residents.		1 1. An additional fire drill for the 3rd shift shall be performed in	
	Findings include:		the month of July, the beginning of	
	I manage menual		the 3rd quarter.	
	Based on record review on 07/08/2024 between		2 2. Additional reminders have	
	10:45 AM and 2:45 PM with the Assistant		been instituted through the TELs	
	Maintenance Director and the Maintenance		system to specifically remind the	
	Director, no documentation for a 2024 second		team of which fire drill is due to be	
	quarter 3rd shift fire drill. Based on interview at		completed.	
	the time of record review, the Maintenance			
	Director agreed there was no documentation for a		Harris and an area interest of the state of	
	2024 second quarter 3rd shift fire drill.		How other residents having the	

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

Page 15 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/08/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This finding was re	viewed with the Maintenance tive Director at the exit		potential to be affected by the same practice will be identified and what corrective action(s) be taken?	d
	3.1-19(b) 3.1-51(c)			All residents and staff in the facility could be affected.	
				What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not reconstruction. 1 1. Additional reminders h	nges e cur?
				been instituted through the TE system to specifically remind to team of which fire drill is due to completed. 2 2. Ongoing review by the or his designee, will be perform to ensure scheduled inspectionare being completed and followup on as planned.	the to be ED, med ns
				How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place?	ent at
				1 1. For Quality Assurance the Maintenance Supervisor, of designee, will review for proper performed fire drills 5 days a way for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2 2. Findings will be reported	or his erly week

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

the ED and the QA Committee for

Page 16 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155665	1	A. BUILDING <u>01</u> B. WING		07/08/2024	
		100000	D		PRESS CITY OF THE COR	017007	2021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD NRY STREET		
MAJESTI	C CARE OF NORT	H VERNON	_		VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	6 months and will continue un	+iI	DATE
					100% compliance has been	ui	
					achieved.		
					By what date the systemic		
					changes for each deficiency w	ʻill	
					be completed? 7.28.24		
K 0741	NFPA 101						
SS=E	Smoking Regulation						
Bldg. 01	Smoking Regulation						
		ns shall be adopted and					
	provisions:	ess than the following					
	•	be prohibited in any room,					
		nent where flammable					
	liquids, combustib	le gases, or oxygen is					
		d in any other hazardous					
		area shall be posted with					
	-	SMOKING or shall be					
	smoking.	ernational symbol for no					
	•	occupancies where					
	smoking is prohibi						
	prominently placed	d at all major entrances,					
		vith language that prohibits					
	smoking shall not						
		tients classified as not					
	responsible shall b	nt of 18.7.4(3) shall not					
		atient is under direct					
	supervision.						
	•	ncombustible material and					
	-	e provided in all areas					
	where smoking is						
	` '	rs with self-closing cover					
		ashtrays can be emptied					
	snall be readily av	ailable to all areas where ed					
	18.7.4, 19.7.4	 -					

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

Page 17 of 21

CENTERS FOR MEDICARE & MEDICAID SERVICES

l l		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		1	A. BUILDING <u>01</u> B. WING			COMPLETED 07/08/2024	
100000		B. W1	_		07/06/	2024	
NAME OF F	PROVIDER OR SUPPLIEF	t .			CADDRESS, CITY, STATE, ZIP COD		
MAJESTIC CARE OF NORTH VERNON				ENRY STREET 'H VERNON, IN 47265			
WAJESTIC GARE OF NORTH VERNOR				11 VERNOIN, IIN 47200			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PRIFFIY (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		view, observation and	K 0'		What corrective action(s) will be	ne	07/28/2024
		ty failed to ensure the metal	11.0	, 11	accomplished for those reside		0772072021
		f-closing cover into which			found to have been affected b		
	ashtrays can be emp	otied of noncombustible			deficient practice?	-	
	material and safe de	esign was free of combustible					
		king area near the kitchen. This			The red metal cigarette dispos	sal	
	-	ould affect residents, staff, and			container with the self-closing		
	visitors in this smol	king area.			cover was emptied of all conte	ents.	
	Findings include:						
	i maniga metade.				How other residents having th	e	
	Based on observation	on during a tour of the facility			potential to be affected by the	·	
		veen 2:45 PM and 4:45 PM with			same practice will be identified	t	
	the Maintenance Di	rector, cigarette containers			and what corrective action(s)		
	and plastic wrappin	g were observed in the red			be taken?		
	metal container with	h a self-closing cover into					
	-	be emptied of noncombustible			All residents and staff in the		
		esign in the smoking area near			facility could be affected.		
	the kitchen.				NA/Is at many a summary will be a most inch	_	
	Rosed on interview	at the time of observation, the			What measures will be put into place and what systemic chan		
		tor agreed there was cigarette		will be made to ensure		-	
		tic wrapping in the container.		deficient practice does not r			
	1	11 8					
		viewed with the Executive			An inservice training session v	vas	
		aintenance Director at the exit			provided for the staff who use	that	
	conference.				area to smoke to clarify the pr	oper	
					use of the separate cigarette a	and	
	3.1-19(b)				trash containers.		
					How the corrective action(s) w	vill be	
					monitored to ensure the defici		
					practice will not recur, i.e., who	at	
					quality assurance program wil		
					put into place?		
					1 1. For Quality Assurance		
					the Maintenance Supervisor, of designee, will review for prope		
					designee, will review for prope	use	

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet Page 18 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	of correction (155665) X1) PROVIDER/SUPPLIER/CLIA (155665)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/08/2024
	PROVIDER OR SUPPLIER IC CARE OF NORTH VERNON	701 HE	ADDRESS, CITY, STATE, ZIP COD INRY STREET I VERNON, IN 47265	
(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 APPROPRIA DEFICIENCY)	5.112
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the	TAG	of the separate cigarette and a containers 5 days a week for a weeks, then weekly for 6 wee then monthly for an additional months. 2 2. Findings will be reported the ED and the QA Committed 6 months and will continue und 100% compliance has been achieved. By what date the systemic changes for each deficiency we be completed? 7.28.24	trash 2 ks, 4 ed to e for til
	monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.			
	Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent			

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPI			COMPL	ETED
		155665	B. WI	NG	_	07/08/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R		l	NRY STREET		
MAJESTIC CARE OF NORTH VERNON				I VERNON, IN 47265			
	1		1				
(X4) ID		STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL					COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	nance and testing of stored					
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		e inspected annually, and a dically exercising the					
	1 ' - '	tablished according to					
	1	uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
		arked, readily identifiable,					
		n normal power circuits.					
	1	ssibility of damage of the					
		source is a design					
	consideration for i						
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	(NFPA 70)					
	Based on record rev	view and interview, the facility	K 0	918	What corrective action(s) will b	е	07/28/2024
	failed to ensure an	annual fuel quality test was			accomplished for those reside	nts	
	l -	acility's diesel powered			found to have been affected by the		
	_	9, Health Care Facilities Code,			deficient practice?		
		on 6.5.4.1.1.2 states Type 2 EES					
	,	l System) generator sets shall			The Annual Fuel Quality Test		
	_	sted in accordance with			documentation was discovered		
		Section 6.4.4.1.1.3 states			following the survey visit. The		
		be performed in accordance			documentation will be filed in a		
		andard for Emergency and			manner that allows for effectiv	е	
		tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test			retrieval.		
		at least annually using tests					
	•	at least annually using tests I standards. This deficient			How other residents having the	^	
	practice could affect				potential to be affected by the	-	
	practice could affec	an robidono.			same practice will be identified	1	
	Findings include:				and what corrective action(s)		
	- mamas morado.				be taken?	••••	
	Based on record rev	view with the Maintenance					
		2024 between 10:30 AM and			All residents and staff in the		
		nentation of an annual fuel			facility could be affected.		
		liesel generator was available			,		
		ne of the survey. Based on			What measures will be put into		
		e of records review, the			place and what systemic chan		
			1		· ·		

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

Event ID:

J8M521 Facility ID: 010996

If continuation sheet Page 20 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) will be made to ensure that deficient practice does not 1 1. More effective filing Annual Fuel Quality Test documentation has been at the Maintenance Supervisor ongoing inspection follow-12 2. Ongoing review by or his designee, will be performed to ensure scheduled insperare being completed and four on as planned. How the corrective action(smonitored to ensure the deficiency)	t the recur? g of added to or's up. the ED, afformed ctions ollowed s) will be efficient
				practice will not recur, i.e., quality assurance program put into place? 1 1. For Quality Assura the Maintenance Supervise designee, will review for Al Fuel Quality Test documer days a week for 2 weeks, tweekly for 6 weeks, then in for an additional 4 months. 2 2. Findings will be repithe ED and the QA Committed 6 months and will continue 100% compliance has bee achieved. By what date the systemic changes for each deficiency be completed? 7.28.24	nce, or, or his nnual ntation 5 then nonthly orted to ittee for e until

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

Event ID:

J8M521

Facility ID: 010996

If continuation sheet

Page 21 of 21