STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING -- B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/08/2024 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Emergency Preparedness survey, Majestic Care of North Vernon was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 101. Quality Review completed on 07/15/24	E 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan 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.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/08/2024 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Life Safety Code survey, Majestic Care Of North Vernon was found not in compliance with	K 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of July 18, 2024.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Phil Ford	Executive Director	07/24/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 101 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 07/15/24		**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.**	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 closet doors in the beauty shop was equipped with a locking mechanism which was able to be unlocked from the inside in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect staff and at least 2 residents	K 0200	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 1. The slide lock on the beauty shop closet door has been	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the beauty shop area. Findings include: Based on observation 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 shop was equipped with a key lock which was unable to be opened from the inside. Based on interview at the time of observation, the Maintenance Director agreed the door had a key lock and was unable to be opened from the inside. The Maintenance Director stated the beautician uses the closet to store her items when in the beauty shop. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 bathrooms near the Executive Director's office which were able to be unlocked from the inside in case of fire or other emergencies were readily accessible in accordance with LSC 7.1.10.1. This deficient practice could affect up to 2 staff, residents, and visitors occupying the bathrooms. Findings include: Based on observation on 07/08/2024 between 2:45 and 4:45 PM during a tour of the facility with the Maintenance Director, the 2 bathrooms near the Executive Director's office were observed to have a key lock and a slide lock on the doors. The slide locks on the bathroom doors do not allow the doors to be opened from the outside in the event		removed. 2 2. The slide locks on the Guest Bathroom doors have been removed. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Guests and Staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 1. Inspection for inappropriate locking mechanisms has been added to the Maintenance Supervisor's ongoing inspection schedule. 2 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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 1. For Quality Assurance, the Maintenance Supervisor, or his	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of an emergency. Based on interview at the time of the observation, the Maintenance Director stated he could hit the door with his body to open the door if needed. At the time of the exit conference, the Executive Director stated residents are not to use these bathrooms as they are for staff and visitors only. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		designee, will review for inappropriate locking mechanisms 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 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the doors to Housekeeping 3 and Housekeeping 4 which were over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff, visitors, and residents in this smoke compartment. At the time of observation, 2 staff members were located in the housekeeping area. This smoke compartment also contains offices, the kitchen, the Peony Cafe, and the Pavilion. Findings include: Based on observations on 07/08/2024 between 2:45 PM and 4:45 PM with the Maintenance Director, the doors to housekeeping rooms 3 and 4 were not equipped with self-closing mechanisms. Housekeeping 3 was filled with cleaning rags, linens, and similar items on freestanding shelves with open floorspace. Housekeeping 4 contained over 16 cardboard boxes, decorations, and at least 21 bottles of alcohol based chemicals housed on metal freestanding shelves, a floor cleaning machine, and other housekeeping items. Both rooms appeared to be over 50 square feet. Based on	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The identified housekeeping doors now have self-closing mechanisms installed. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 1. Inspection for appropriate locking mechanisms has been added to the Maintenance Supervisor's ongoing inspection	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview at the time of observation, the Maintenance Director agreed there was a significant amount of combustible materials in the aforementioned locations with no self-closing mechanisms on the doors. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		schedule. 2 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review for appropriate locking mechanisms 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 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be 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 records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on record review with the Maintenance Director on 07/08/2024 between 10:45 AM and	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The monthly sprinkler valve and gauge inspections documentation was discovered following the survey visit. The documentation will be filed in a manner that allows for effective retrieval. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2:45 PM, no documentation was able to be provided regarding monthly valve and gauge inspections at the time of the survey. Based on interview at the time of record review, the Maintenance Director stated he was unable to located the monthly valve and gauge documentation in the physical paperwork or on TELS but was able to locate the quarterly sprinkler system documents completed by SafeCare. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		deficient practice does not recur? 1 1. More effective filing of monthly sprinkler valve and gauge inspection documentation has been added to the Maintenance Supervisor's ongoing inspection follow-up. 2 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review for monthly sprinkler valve and gauge inspections documentation 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 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 fire extinguishers in the maintenance office, 1 of 1 fire extinguishers in the D hall mechanical room, 1 of 1 fire extinguishers in the water softener room, and 1 of 1 fire extinguishers in the washer room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.	K 0355	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The four identified fire extinguishers have been checked and judged as functional and ready for service. Their tags have 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) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 1. Additional identifiers indicating certain extinguisher locations have been added. 2 2. A facility floor plan has been utilized to identify each location of the facility's fire	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect at least 5 staff in these areas. Findings include: Based on observation during a tour of the facility on 07/08/2024 between 2:45 PM and 4:45 PM with the Maintenance Director, the monthly inspection tag on the fire extinguishers located in the maintenance office, D hall mechanical room, water softener room, and washer room were not marked as being checked for June 2024. Based on interview at the time of observation, the Maintenance Director agreed the fire extinguishers in the aforementioned locations were not checked for June and asked if he could sign the tag for June at the time of observation. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		extinguishers to assist in inspection completion. 3 3. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the location of each fire extinguisher 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 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility 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	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could affect 2 residents, staff, and visitors to the room. Findings include: Based on observation during a tour of the facility on 07/08/2024 between 2:45 and 4:45 PM with the Maintenance Director, the door to room A 107 was unable to latch into the frame. Based on interview at the time of the observation, the Maintenance Director agreed the door to room A107 was unable to latch. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		The one resident door that did not latch securely has been repaired and is functioning as it should. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 1. Inspection of each resident doors 5 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, or his designee's, responsibilities to ensure proper closure. 1 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			2 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the proper closure of each resident's door 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 3 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
K 0511 SS=B Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical boxes in the central nurses' station was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect approximately 6 residents, staff, and visitors in the central nurses' station area. Findings include:	K 0511	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This one electrical box cover was installed and corrected by the Maintenance Assistant at the time of observation. How other residents having the	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation during a tour of the facility on 07/08/2024 between 2:45 PM and 4:45 PM with the Executive Director, the electrical box at the central nurses' station did not have a coverplate attached. Based on interview at the time of observation, the Maintenance Director stated his assistant had been working on this earlier in the day. This was corrected by the Maintenance Assistant at the time of observation. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 1. Inspection of properly installed electrical cover plates 5 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 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 100% compliance has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 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 failed to conduct 3rd shift quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 07/08/2024 between 10:45 AM and 2:45 PM with the Assistant Maintenance Director and the Maintenance Director, no documentation for a 2024 second quarter 3rd shift fire drill. Based on interview at the time of record review, the Maintenance Director agreed there was no documentation for a 2024 second quarter 3rd shift fire drill.	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 1. An additional fire drill for the 3rd shift shall be performed in the month of July, the beginning of the 3rd quarter. 2 2. Additional reminders have been instituted through the TELs system to specifically remind the team of which fire drill is due to be completed. How other residents having the	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Maintenance Director and Executive Director at the exit conference. 3.1-19(b) 3.1-51(c)		potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 1. Additional reminders have been instituted through the TELs system to specifically remind the team of which fire drill is due to be completed. 2 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review for properly performed fire drills 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			6 months and will continue until 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review, observation and interview, the facility failed to ensure the metal container with a self-closing cover into which ashtrays can be emptied of noncombustible material and safe design was free of combustible material in the smoking area near the kitchen. This deficient practice could affect residents, staff, and visitors in this smoking area. Findings include: Based on observation during a tour of the facility on 07/08/2024 between 2:45 PM and 4:45 PM with the Maintenance Director, cigarette containers and plastic wrapping were observed in the red metal container with a self-closing cover into which ashtrays can be emptied of noncombustible material and safe design in the smoking area near the kitchen. Based on interview at the time of observation, the Maintenance Director agreed there was cigarette containers and plastic wrapping in the container. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)	K 0741	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The red metal cigarette disposal container with the self-closing cover was emptied of all contents. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? An inservice training session was provided for the staff who use that area to smoke to clarify the proper use of the separate cigarette and trash containers. 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 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review for proper use	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			of the separate cigarette and trash containers 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 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	
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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM, no documentation of an annual fuel quality test for the diesel generator was available for review at the time of the survey. Based on interview at the time of records review, the	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Annual Fuel Quality Test documentation was discovered following the survey visit. The documentation will be filed in a manner that allows for effective retrieval. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents and staff in the facility could be affected. What measures will be put into place and what systemic changes	07/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director stated the facility does have a diesel generator and thought a fuel quality test may have been completed but did not have the documentation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		will be made to ensure that the deficient practice does not recur? 1 1. More effective filing of Annual Fuel Quality Test documentation has been added to the Maintenance Supervisor's ongoing inspection follow-up. 2 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review for Annual Fuel Quality Test documentation 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 100% compliance has been achieved. By what date the systemic changes for each deficiency will be completed? 7.28.24	