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	09/16/2022

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 07/25/22 & 07/26/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/16/22 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 109. Quality Review completed on 09/19/22	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 9-19-22 to the life safety survey completed on 9-16-2022.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/25/22 & 07/26/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/16/22 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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	At this PSR survey, Majestic Care of North Vernon was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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. All 61 resident sleeping rooms were surveyed except for Rooms A100 through A104 due to Covid-19 concerns. The facility has a capacity of 120 and had a census of 109 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 09/19/22		compliance effective 9-19-22 to the life safety survey completed on 9-16-2022.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain the means of egress free from	K 0211	It is the practice of this facility to ensure that the means of egress	09/19/2022

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	obstructions in 2 of 8 means of egress. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Director of Nursing (DON) and the Assistant Maintenance Director during a tour of the facility from 11:30 a.m. to 12:05 p.m. on 09/16/22, a large, padded wheelchair was stored in the corridor outside Room D101 and blocked nearly half of the eight-foot-wide corridor. In addition, one large stainless steel meal serving cart, a cart with cardboard boxes and six oxygen concentrators were stored in the corridor outside the kitchen near the exit door of the facility by the oxygen storage and transfilling room. Based on interview at the time of the observations, the DON had the padded wheelchair relocated to a shower room, but the DON and the Assistant Maintenance Director agreed the aforementioned means of egress were not continuously maintained free of all obstructions to full use in case of emergency. This finding was reviewed with the DON and the Assistant Maintenance Director during the exit conference. This deficiency was cited on 07/26/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		are maintained free of all obstructions. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The bariatric wheelchair is being stored in the beauty shop when not in use. The steel dining cart and black cart stored in kitchen. The boxes were disposed of in trash and oxygen concentrators were returned to oxygen company and/or stored in oxygen room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The resident in room D101 is a bariatric resident whom has bariatric equipment. When resident is laid down for nursing care, the bariatric chair is set outside her room until care completed. Resident has tendency to refuse to get up and return to chair after care. All staff have been educated to return chair	

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			to designated storage spot in beauty shop. Dietary serving cart is being stored in the kitchen along with black cart. Card board boxes were disposed of in proper dumpster. Staff were educated on when the delivery truck comes, boxes must be broken down and immediately taken to dumpster. Oxygen concentrators that were broke have been returned to oxygen company. All staff have been reeducated on not storing anything in this hallway. All other means of egress were audited and no issues found. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director and/or her designee will audit the entire facility daily for 30 days. bi weekly x 4 weeks and then weekly thereafter. Findings will be remedied immediately and staff reeducated and return demonstration on policy performed. All findings and discovery will be discussed at the daily continuous quality improvement meeting. Executive Director to monitor	