	T OF HEALTH AND HU R MEDICARE & MEDIC						TED: 07/05/2024 RM APPROVED B NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIEI			5233 R	ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE URGH, IN 47630		
(X4) ID PREFIX TAG E 0000	(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 06/10 Facility Number: 0 Provider Number: AIM Number: 200 At this Emergency Care of Newburgh with Emergency Pr Medicare and Mediand Suppliers, 42 C The facility has 104 the survey, the censury of the requirement at MET as evidenced	20/24 2011049 20155670 20158520 Preparedness survey, Majestic was found not in compliance reparedness Requirements for icaid Participating Providers CFR 483.73. 4 certified beds. At the time of sus was 97. Impleted on 06/13/24 42 CFR, Subpart 483.73 is NOT	E 00	000	By submitting the enclosed materials, we are not admittir truth or accuracy of any spec findings or allegations. We re the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequests that the plan of correction be considered our allegation of compliance effect July 3, 2024, to the Life Safett Code survey completed on 6/10/2024. We respectfully request a paper review and we provide any additional informatic requested.	ific serve gs or e cility ctive	
E 0015 SS=F		8.113(b)(6)(iii), 441.184(b) 483 475(b)(1) 483 73(b)(1)					

Bldg. --

485.625(b)(1)

Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), 441.184(b)(1), 460.84(b)(1), 482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at

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

TITLE

(X6) DATE

Brandi Thompson **Executive Director** 07/02/2024

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIEI			5233 RO	DDRESS, CITY, STATE, ZIP COD OSEBUD LANE RGH, IN 47630		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	PR	ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤE	(X5) COMPLETION
TAG	paragraph (a)(1) of communication plus section. The policible reviewed and fannually for LTC	of this section, and the an at paragraph (c) of this cies and procedures must updated every 2 years facilities]. At a minimum, rocedures must address		ΓAG	DEFICIENCY)		DATE
	(1) The provision staff and patients shelter in place, ir to the following: (i) Food, water, manual supplies						
	supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary						
	storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.						
	*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must						
	hospice employee	of subsistence needs for es and patients, whether shelter in place, include, but					
	(A) Food, water, r supplies.(B) Alternate sour the following:(1) Temperatures	nedical, and pharmaceutical rces of energy to maintain to protect patient health r the safe and sanitary					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED
		155670	B. W	NG		06/10	/2024
		•		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			OSEBUD LANE		
MAJEST	IC CARE OF NEW	BURGH	_	NEWBURGH, IN 47630			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	storage of provision						
	(2) Emergency lig	•					
	(3) Fire detection, extinguishing, and alarm systems.						
	(C) Sewage and v						
		view and interview, the facility	E 00)15	E 015 Subsistence needs for	Staff	07/03/2024
		ergency preparedness policies			and Patients		
	_	lude at a minimum, (1) The			What corrective action(s) will I		
	_	tence needs for staff and			accomplished for those reside		
	•	they evacuate or shelter in			found to have been affected b	-	
	_	are not limited to the following:			deficient practice; No reside	ents	
		dical, and pharmaceutical			experienced any negative		
	* *	nate sources of energy to			outcomes due to the alleged		
		peratures to protect resident			deficient practice. How oth		
		nd for the safe and sanitary			residents having the potential		
		ns; (B) Emergency lighting; (C)			be affected by the same defic		
		nguishing, and alarm systems;			practice will be identified and	wnat	
		d waste disposal in accordance			corrective action(s) will be		
		3(b)(1). This deficient practice			taken; All residents could		
	could affect all occ	upants.			potentially be affected by the		
	Findings include:				alleged deficient practice.	an.	
	rindings include.				Emergency Preparedness Plant updated with provisions of	an	
	Rosed on review of	the Emergency Preparedness			subsistence needs for staff ar	d	
		etween 9:45 a.m. and 2:15 p.m.			residents in the event of	iu	
		Director and Maintenance			evacuation or the need to she	lter	
		e plan provided did not			in place, including company	1101	
		r, medical, and pharmaceutical			names and phone numbers. V	Vhat	
		residents health and safety in			measures will be put into plac		
		hermore, the plan provided did			and what systemic changes w		
		ency power to maintain			be made to ensure that the	•••	
	_	steet resident health and safety.			deficient practice does not		
		at the time of record review,			recur; Emergency Water,		
		ctor and Maintenance Director			Emergency Food, Emergency		
		provided did not address the			Oxygen, Emergency Resident		
	previously mention				supplies, including pharmacy,		
	l i i i i i i i i i i i i i i i i i i i				Policies updated in the		
	This finding was re	eviewed with the Executive			Emergency Preparedness		
		of Nursing, and Maintenance			Plan. How the corrective action	n(s)	
	Director during the exit conference				will be monitored to ensure the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. BUILDING B. WING		COMP 06/10		
	PROVIDER OR SUPPLIER		5233 R	ADDRESS, CITY, STATE, ZIP COI COSEBUD LANE URGH, IN 47630)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
				deficient practice will not i.e., what quality assuran program will be put into met, an action plan wimplemented.	ce place; edness juarterly nold is	
E 0018 SS=F Bldg	and (v), 441.184(b 483.475(b)(2), 483 485.920(b)(1), 486 Procedures for Tra §403.748(b)(2), §4 (ii) and (v), §441.1 §482.15(b)(2), §48	3.73(b)(2), 485.625(b)(2), 5.360(b)(1), 494.62(b)(1) acking of Staff and Patients 116.54(b)(1), §418.113(b)(6) 84(b)(2), §460.84(b)(2), 33.73(b)(2), §483.475(b)(2), 185.920(b)(1), §486.360(b)				
	must develop and preparedness policon the emergency (a) of this section, paragraph (a)(1) o communication plasection. The polici reviewed and update [annually for LTC to the properties of the polici reviewed and update [annually for LTC to the properties of the pr	implement emergency cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the an at paragraph (c) of this es and procedures must be ated at least every 2 years facilities]. At a minimum, rocedures must address				
	on-duty staff and s [facility's] care duri on-duty staff and s relocated during th must document the	m to track the location of sheltered patients in the ing an emergency. If sheltered patients are ne emergency, the [facility] e specific name and eliving facility or other				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. BUILDING B. WING	CONSTRUCTION	COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIER		5233	T ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE BURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	*[For PRTFs at §4 §483.73(b), ICF/III §460.84(b):] Polici system to track the and sheltered resi ICF/IID or PACE] emergency. If onresidents are relocemergency, the [FPACE] must docu and location of the location. *[For Inpatient Hose Policies and procedii) Safe evacuation includes consideranceds of evacuee transportation; ide location(s) and priof communication assistance. (v) A system to tracemployees' on-duthe hospice's care the on-duty emploare relocated during hospice must document and location of the location. *[For CMHCs at § procedures. (2) Sac CMHC, which included treatment need responsibilities; traces in tracemployees. (2) Sac CMHC, which included treatment need responsibilities; traces in traces in the second includes the s	PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other spice at §418.113(b)(6):]			
		f communication with			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. BU	A. BUILDING B. WING			COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	procedures. (2) A documentation that actual donor information, and savailability of reconstruction of the savailabilities, are savailabilities, are savailabilities, are savailabilities, are savailable of the savailabilities, are savailable of the savailab	86.360(b):] Policies and system of medical at preserves potential and mation, protects otential and actual donor ecures and maintains the rds. 94.62(b):] Policies and afe evacuation from the	E 0	018	E 018 – Procedures for Tracki Staff and Patients What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially affected by the alleged deficient practice. Staff and Resident Tracking for will be placed in the Emergence Preparedness Binder. What measures will be put into	e be nt bernt cy	07/03/2024

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024	
	ROVIDER OR SUPPLIER			5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	confirmed there was no system to track the location of on-duty staff and sheltered residents in the event of an emergency in the available plan. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance			place and what systemic changes will be made to ensure that the deficient practice does not recur;			
	_	f Nursing, and Maintenance			Emergency Preparedness Resident and Staff Tracking F and Resident and Staff Track Forms placed in the Emerger Preparedness binder. How the corrective action(s) we monitored to ensure the defice practice will not recur, i.e., who quality assurance program with put into place;	ing cy vill be ient at	
					Emergency Preparedness Bir will be reviewed by QAPI at minimum quarterly and as ne If % threshold is not met, an action plan will be implemente	eded.	
E 0020 SS=F Bldg	441.184(b)(3), 482 483.73(b)(3), 485. 485.727(b)(1), 485 494.62(b)(2) Policies for Evac. §403.748(b)(3), §4 (ii), §441.184(b)(3) (3), §483.73(b)(3), (1), §485.625(b)(3), §485.920(b)(2), §4 [(b) Policies and p must develop and	6.54(b)(2), 418.113(b)(6)(ii), 6.215(b)(3), 483.475(b)(3), 625(b)(3), 485.68(b)(1), 6.920(b)(2), 491.12(b)(1), and Primary/Alt. Comm. 116.54(b)(2), §418.113(b)(6)), §460.84(b)(3), §482.15(b) §483.475(b)(3), §485.68(b)), §485.727(b)(1), 191.12(b)(1), §494.62(b)(2) rocedures. The [facilities] implement emergency cies and procedures, based					

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	INT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670		UILDING	NSTRUCTION	(X3) DATE COMPL 06/10/	ETED		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630						
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE		
	(a) of this section, paragraph (a)(1) of communication placetion. The policing reviewed and upon an analysis of the policies and puthe following: [(3) or (1), (2), (6)] [facility], which incommunication local alternate means of external sources of the following: *[For RNHCls at § §416.54(b)(2):] Safe evacuation for which includes the (i) Consideration of (ii) Staff responsibility (iii) Transportation (iv) Identification of (v) Primary and all communication wassistance. * [For CORFs at § Rehabilitation Age §485.727(b)(1), a §494.62(b)(2):] Safe evacuation for Rehabilitation Age Agencies as Proven Therapy and Speservices; and ES	S403.748(b)(3) and ASCs at rom the [RNHCl or ASC] e following: of care needs of evacuees. bilities.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. Bl	A. BUILDING CC			date survey completed 06/10/2024	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the patients. * [For RHCs/FQH evacuation from the includes appropria staff responsibiliting patients. Based on record responsibiliting patients. Evacuation from the consideration of case evacuation from the consideration of experiments and alternation with external source with 42 CFR 483.7 could affect all occurrents. Based on review of Plan on 06/10/24 be with the Executive Director present, the within the Emerger however, it was a geolific. Based on review, the Execution Director acknowled the Emergency Preplan and not facility. This finding was responsibiliting the second properties of the patients.	Cs at §491.12(b)(1):] Safe he RHC/FQHC, which ate placement of exit signs; es and needs of the view and interview, the facility ergency preparedness policies lude information for safe e LTC facility, which includes re and treatment needs of ponsibilities; transportation; acuation location(s); and ate means of communication es of assistance in accordance 3(b) (3). This deficient practice upants. The Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance ere was an evacuation plan and preparedness Plan, eneric plan and not facility interview at the time of record ve Director and Maintenance alged the evacuation plan within paredness Plan was a generic y specific.	EO	020	E 020 – Policies for Evacuation and Primary/Alternate Communications What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially affected by the alleged deficient practice. Facility specific plans will be put interplace and what systemic chant will be made to ensure that the deficient practice does not	be nts y the e be nt ut	07/03/2024
					recur; Evacuation policy updated wit facility specific information.	h	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION _ 	COMP	E SURVEY PLETED 0/2024
	ROVIDER OR SUPPLIER		5233 F	ADDRESS, CITY, STATE, ZIP (ROSEBUD LANE URGH, IN 47630	COD	
(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 CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	403.748(b)(5), 410 441.184(b)(5), 484 483.73(b)(5), 484 485.68(b)(3), 485 486.360(b)(2), 49 Policies/Procedure Documentation §403.748(b)(5), §	6.54(b)(4), 418.113(b)(3), 2.15(b)(5), 483.475(b)(5), 102(b)(4), 485.625(b)(5), 727(b)(3), 485.920(b)(4), 1.12(b)(3), 494.62(b)(4)		Evacuation maps upd door locations and on evacuation locations. How the corrective acmonitored to ensure the practice will not recur, quality assurance proput into place; Emergency Prepared will be reviewed by Quantinimum quarterly and If 100% threshold is not action plan will be imposed.	ated with fire site stion(s) will be he deficient , i.e., what gram will be ness Binder API at d as needed. ot met, an	
	(5), §483.73(b)(5) §484.102(b)(4), § (5), §485.727(b)(3) §486.360(b)(2), §4 [(b) Policies and p must develop and preparedness poli on the emergency (a) of this section, paragraph (a)(1) of	, §483.475(b)(5), 485.68(b)(3), §485.625(b)				

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		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155670	A. BU B. WI	JILDING ING		COMPL 06/10		
		100070	D. W	_	ADDRESS STEW ST. TO ST. CO.	00/10/	-LVLT	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE			
MAJEST	IC CARE OF NEW	BURGH			JRGH, IN 47630			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL B. I. S.C. IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
IAU		R LSC IDENTIFYING INFORMATION cies and procedures must	+	IAU			DATE	
	· ·	updated at least every 2						
		or LTC facilities]. At a						
	minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical							
	_ , , , , , , , , , , , , , , , , , , ,	at preserves patient						
		ects confidentiality of patient						
	information, and	secures and maintains						
	availability of records. *[For RNHCls at §403.748(b):] Policies and procedures. (5) A system of care							
		at does the following:						
	(i) Preserves pati	-						
	1 ' '	dentiality of patient						
	information.							
	, ,	maintains the availability of						
	records.							
	*[For OPOs at §4	86.360(b):] Policies and						
	. , ,	A system of medical						
		at preserves potential and						
	actual donor infor	· ·						
		ootential and actual donor secures and maintains the						
	availability of reco							
		view and interview, the facility	E 00	023	E 023 – Policies and Procedu	res	07/03/2024	
	failed to ensure em	ergency preparedness policies			for Medical Documentation			
	_	lude a system of medical			What corrective action(s) will			
	documentation that	-			accomplished for those reside			
		ets confidentiality of resident ecures and maintains the			found to have been affected b	y the		
					deficient practice;			
	availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants.				No residents experienced any	,		
					negative outcomes due to the			
					alleged deficient practice.			
	Findings include:							
					How other residents having th	ie		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155670		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
MAJEST (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF Plan on 06/10/24 be with the Executive Director, policies as system of medical cresident information the availability of review within the EB Based on interview the Executive Directory or program documentation that information, protectinformation, and se availability of record addressed in the Entry This finding was re-	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance and procedure that included a documentation that preserves an, protects confidentiality of an, and secures and maintains ecords was not available for amergency Preparedness Plan. at the time of record review, etor said the facility uses the E-MAR for a system of medical preserves resident ts confidentiality of resident cures and maintains the ads, however, it is not mergency Preparedness Plan. viewed with the Executive of Nursing, and Maintenance				be nt g en o ges e d to dent ill be ent at I be der	(X5) COMPLETION DATE

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. BUIL	A. BUILDING COMPLETED B. WING 06/10/2024			ETED	
	PROVIDER OR SUPPLIER			5233 RC	DDRESS, CITY, STATE, ZIP COD DSEBUD LANE RGH, IN 47630		
WIAGEOT	O OAIRE OF NEWE				11011, 111 47 000		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
E 0024		6.54(b)(5), 418.113(b)(4),					
SS=F Bldg	441.184(b)(6), 482 483.73(b)(6), 484. 485.68(b)(4), 485. 491.12(b)(4), 494. Policies/Procedure §403.748(b)(6), §4 §441.184(b)(6), §4 §485.68(b)(4), §48 §485.920(b)(5), §4 [(b) Policies and p must develop and preparedness polic on the emergency (a) of this section, paragraph (a)(1) o communication pla section. The polic be reviewed and u years [annually for	2.15(b)(6), 483.475(b)(6), 102(b)(5), 485.625(b)(6), 727(b)(4), 485.920(b)(5), 62(b)(5) es-Volunteers and Staffing 116.54(b)(5), §418.113(b)(4), 160.84(b)(7), §482.15(b)(6), 133.475(b)(6), §484.102(b)(5), 15.625(b)(6), §485.727(b)(4), 191.12(b)(4), §494.62(b)(5). rocedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the an at paragraph (c) of this ies and procedures must updated at least every 2 LTC facilities]. At a cies and procedures must					
	of volunteers in an emergency staffing process and role for Federally designate professionals to act an emergency. *[For RNHCls at § procedures. (6) The emergency and ot strategies to address emergency.	7) as noted above] The use a emergency or other g strategies, including the or integration of State and ted health care ddress surge needs during 403.748(b):] Policies and he use of volunteers in an her emergency staffing ess surge needs during an					

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	AN OF CORRECTION IDENTIFICATION NUMBER 155670 AN OF CORRECTION A. BUILDING B. WING		INSTRUCTION	COMPLETED 06/10/2024			
	ROVIDER OR SUPPLIER			5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION he use of hospice		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	emergency staffing process and role for Federally designar professionals to an emergency.	emergency and other g strategies, including the for integration of State and ted health care ddress surge needs during view and interview, the facility	EO	024	E 024 – Policy and Procedure:	s –	07/03/2024
	failed to ensure eme and procedures incl an emergency or oth strategies, including integration of State care professionals to an emergency in acc	ergency preparedness policies ude the use of volunteers in her emergency staffing g the process and role for or Federally designated health to address surge needs during cordance with 42 CFR deficient practice could affect	E	024	Volunteers and Staffing What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice.	oe nts y the	07/03/2024
	Plan on 06/10/24 be with the Executive Director present, the the use of volunteer interview at the time Director confirmed address the use of v	the Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance e facility's plan did not address in an emergency. Based on e of review, the Executive the plan provided did not olunteers in an emergency. Viewed with the Executive f Nursing, and Maintenance exit conference.			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially laffected by the alleged deficient practice. Policy and Procedure address the use of volunteers or other emergency staffing strategies address surge needs during an emergency. What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not	oe nt ing to n	
					recur;		

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	OF CORRECTION	IDENTIFICATION NUMBER 155670	A. BUILDING B. WING	INSTRUCTION	COMPLETED 06/10/2024	
	ROVIDER OR SUPPLIER		5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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	
E 0029 SS=F Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62(Development of Cos (403.748(c), §416 (§441.184(c), §460 (§483.73(c), §485.68 (c), §485.68 (c), §485.69 (c). (c) The [facility] must emergency preplan that complies local laws and must least every 2 ye facilities]. Based on record reversalled to develop and	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),	E 0029	Emergency Preparedness Emergency Staffing policy updated and facility specific. How the corrective action(s) w monitored to ensure the deficie practice will not recur, i.e., wha quality assurance program wil put into place; Emergency Preparedness Bin will be reviewed by QAPI at minimum quarterly and as nee If 100% threshold is not met, a action plan will be implemente	ent at libe der eded. an d. 07/03/2024	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and updated at least	and local laws was reviewed annually in accordance with This deficient practice could		accomplished for those reside found to have been affected be deficient practice;	
	Findings include:			No residents experienced any negative outcomes due to the alleged deficient practice.	
	Plan on 06/10/24 be with the Executive Director present, the Preparedness Plan of Plan, however, the generic plan and no on interview at the Director and Mainte Communication Pla Preparedness Plan v specific to the facili	viewed with the Executive f Nursing, and Maintenance		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially affected by the alleged deficient practice. Communication Plan reviewed updated with facility specific information. What measures will be put into place and what systemic charwill be made to ensure that the deficient practice does not recur;	be ent d and o nges
				Emergency Communication Plan updated to reflect facility specific communication information. How the corrective action(s) v monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wi put into place; Emergency Preparedness Bir	vill be ient at Il be

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		5233 F	ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				will be reviewed by QAPI at minimum quarterly and as new lf % threshold is not met, an action plan will be implemented.	
E 0032 SS=F Bldg	441.184(c)(3), 483.73(c)(3), 485.485.68(c)(3), 485.486.360(c)(3), 49 Primary/Alternate §403.748(c)(3), §441.184(c)(3), §483.73(c)(3), §485.68(c)(3), §485.68(c)(3), §491.12(c)(3), §491.12	pust develop and maintain eparedness communication with Federal, State and lest be reviewed and updated ears [annually for LTC mmunication plan must collowing: Iternate means for the the following: Iternate, regional, and local	E 0032	E 032 – Primary/Alternate Me	ans 07/03/2024

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SUR COMPLETE 06/10/202	ED
	PROVIDER OR SUPPLIER		5233 F	ADDRESS, CITY, STATE, ZIP CO. ROSEBUD LANE URGH, IN 47630	D	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CTION ULD BE PROPRIATE CO	(X5) OMPLETION DATE
	and alternate means following: (i) LTC tribal, regional, or l agencies in accorda This deficient pract Finding include: Based on review of Plan on 06/10/24 be with the Executive Director present, the communication pro and an alternate means on interview at the Executive Director agreed the facility of primary and alternate This finding was resulted.	gram that included (3) Primary s for communicating with the facility's staff (ii) Federal, State, ocal emergency management ance with 42 CFR 483.73(c)(3). Since could affect all occupants. The Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance e plan did not include a agram that included a primary cans for communication. Based time of record review the and Maintenance Director does not have a program for attive means for communication.		of Communication What corrective action(s accomplished for those found to have been affect deficient practice; No residents experience negative outcomes due alleged deficient practice. How other residents have potential to be affected be same deficient practice identified and what correction(s) will be taken; All residents could poter affected by the alleged of practice. Communication Plan revupdated with facility speinformation. What measures will be place and what systemic will be made to ensure the deficient practice does in recur; Emergency Communication How the corrective action monitored to ensure the practice will not recur, i.e. quality assurance prograput into place;	residents cted by the Id any to the e. Ing the by the will be ective Intially be deficient Identific Intially be deficient Intially be and cific Intially be deficient Intially be deficient	

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	OF CORRECTION OF CORRECTION 155670 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER IC CARE OF NEWBURGH	5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE URGH, IN 47630	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) BE COMPLETION DATE
			Emergency Preparedness I will be reviewed by QAPI at minimum quarterly and as If % threshold is not met, at action plan will be impleme	t needed. n
E 0033 SS=F Bldg	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c) (4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c) (4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information \$403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c) (4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2024		
	PROVIDER OR SUPPLIEF		5233 F	ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	under 45 CFR 16- provision is not re §484.102(c), COF (6) [(4) or (5)]A mand about the general patients under the permitted under 4- *[For RNHCIs at § for sharing inform documentation for care, as necessar maintain the continuity written election state patient or his or having and the facility's CFR 164.510(b)(4). Based on record revelacked an emergence communication promethod for sharing documentation for facility's care, as ne providers to maintain means, in the event client information about the location of resident permitted under 45.	repatients under the RNHCl's y, with care providers to nuity of care, based on the atement made by the er legal representative. Cs at §491.12(c):] (4) A g information about the and location of patients acare as permitted under 45 k). View and interview, the facility by preparedness gram that included (4) A information and medical residents under the LTC cessary, with other health care in the continuity of care; (5) A of an evacuation, to release as permitted under 45 CFR (5) A means of providing the general condition and s under the facility's care as CFR 164.510(b)(4) in CFR 483.73(c). This deficient	E 0033	E 033 – Methods for Sharing Information What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	nts y the

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Findings include:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155670	B. WI	ING		06/10/	2024
AND PLAN	NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NEWBURGH (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Based on review of the Emergency Preparedness Plan on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Executive Director and Maintenance Director present, no documentation was available for a communication program that included (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release residents information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care. Based on interview at the time of record review, the agreed there was no communication program to indicate a method for sharing information and		A. BU	JILDING ING STREET A 5233 RO	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) All residents could potentially affected by the alleged deficie practice. Reviewed and updated policy procedure addressing method sharing information and medic documentation with other heal care providers to maintain continuity of care. What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not	COMPL 06/10/ 06/10/ TE be nt and s for eal th	ETED
	location of residents Based on interview the agreed there was to indicate a method medical documental LTC facility's care. This finding was rev	s under the facility's care. at the time of record review, s no communication program If for sharing information and tion for residents under the viewed with the Executive If Nursing, and Maintenance				lan o of cal e vill .,	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		5233 R	ADDRESS, CITY, STATE, ZIP COD COSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION
E 0034 SS=F Bldg	441.184(c)(7), 482. 483.73(c)(7), 484. 485.68(c)(5), 485. 491.12(c)(5), 494. Information on Oc §403.748(c)(7), §483.73(c)(7), §483.73(c)(7), §485.68(c)(5) (5), §485.625(c)(7) §491.12(c)(5), §485.625(c)(7), §485.625(c), §485.625(c), §485.625(c), §485.625(c), §485.625(c), §485.625(c), §4	decupancy/Needs 416.54(c)(7), §418.113(c)(7) 482.15(c)(7), §460.84(c)(7), 33.475(c)(7), §484.102(c) , §485.68(c)(5), §485.727(c) 7), §485.920(c)(7), 94.62(c)(7). Thust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC immunication plan must collowing: The ans of providing the [facility's] occupancy, lity to provide assistance, aving jurisdiction, the discontinuous control of the	E 0034	E 034 – Information on	07/03/2024
l	1	,,	1 2 000 1		3770372024

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	l í	UILDING	ONSTRUCTION	(X3) DATE COMPL 06/10/	ETED
	OF PROVIDER OR SUPPLIED		•	5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	providing informat occupancy, needs, assistance, to the at the Incident Commaccordance with 42 deficient practice of Findings include: Based on review of Plan on 06/10/24 be with the Executive Director present, we communication pla providing informat occupancy, needs, assistance, to the at the Incident Commaccordance with 42 review. Based on it review the Executive Director agreed that generic communication aforementioned occupancy occupancy. This finding was resulted.	ogram that included a means of ion about the LTC facility's and its ability to provide athority having jurisdiction or and Center, or designee in a CFR 483.73(c)(7). This ould affect all occupants. The Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance ithin the generic in there was no means of ion about the LTC facility's and its ability to provide athority having jurisdiction or and Center, or designee in a CFR 483.73(c)(7) available for interview at the time of record we Director and Maintenance at there was nothing within the ation plan to include the cupancy, needs, and ability to to the AHJ, IC, or designee.			Occupancy/Needs What corrective action(s) will accomplished for those reside found to have been affected be deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially affected by the alleged deficient practice. Update communication policy procedure addressing a mean providing information about the facility's occupancy, needs, at ability to. What measures will be put interplace and what systemic charm will be made to ensure that the deficient practice does not recur; Emergency Communication Pupdated to reflect facility specific policy and procedure address means of providing information about the facility's occupancy needs and ability to. How the corrective action(s) will accomplished to the facility to accupancy needs and ability to.	ents by the be and as of end onges e flan iffic ing a n	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155670	B. WI	NG		06/10/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF NEWE	BURGH			DSEBUD LANE JRGH, IN 47630		
(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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	monitored to ensure the deficie practice will not recur, i.e., wha quality assurance program will put into place; Emergency Preparedness Bind will be reviewed by QAPI at minimum quarterly and as nee If 100% threshold is not met, a action plan will be implemented	at be der ded. n	DATE
E 0035 SS=F Bldg	§483.73(c)(8); §48 *[For LTC Facilitie [(c) The LTC facilitimaintain an emergency expenses of the communication plane following:] *[For ICF/IIDs at § [(c) The ICF/IID memergency preparate plan that complies local laws and must least every 2 years plan must include (8) A method for semergency plan, to determined is appolients] and their face.	sharing Plan with Patients 33.475(c)(8) s at §483.73(c):] ty must develop and gency preparedness an that complies with d local laws and must be ated at least annually. The an must include all of the 483.475(c):] ust develop and maintain an redness communication with Federal, State and st be reviewed and updated stars. The communication all of the following:] haring information from the hat the facility has ropriate, with residents [or amilies or representatives. riew and interview, the facility	E 00	035	E 035 – LTC and ICF/IID Shar Plan with Patients	ing	07/03/2024

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE S COMPLE 06/10/2	ETED
	PROVIDER OR SUPPLIEI		5233 F	ADDRESS, CITY, STATE, ZIP CO ROSEBUD LANE URGH, IN 47630	D	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE
TAG	communication profor sharing informathat the facility has residents and their accordance with 42 deficient practice of Findings include: Based on review of Plan on 06/10/24 be with the Executive Director present, we communication platharing information the facility has determined the facility has determined their accordance with 42 interview at the times.	gram that included a method tion from the emergency plan determined is appropriate with families or representatives in CFR 483.73(c)(8). This ould affect all occupants. The Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance	TAG	What corrective action(s accomplished for those is found to have been affected deficient practice; No residents experience negative outcomes due alleged deficient practice. How other residents have potential to be affected by same deficient practice identified and what correction(s) will be taken; All residents could potentified by the alleged of practice. The Communication planting accomplished and planting accomplished and potentified a	e) will be residents cted by the ed any to the e. ving the by the will be ective	DATE
	agreed that no docu been created or sha This finding was re	mentation or program has red. viewed with the Executive of Nursing, and Maintenance		reviewed and updated to facility specific informatic sharing information with residents and families rethe Emergency Prepared Plan. What measures will be pplace and what systemic will be made to ensure the deficient practice does not recur; All residents and respon parties issued the Resid Family Notification Fact The Fact Sheet will be is admission and at minimum annually during resident.	o include on for the egarding dness out into c changes hat the not esible eent and Sheet. essued at um	

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	OF CORRECTION	IDENTIFICATION NUMBER 155670	A. BUILDING B. WING	onstruction 	COMPLETED 06/10/2024
	ROVIDER OR SUPPLIER		5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0036 SS=F Bldg	484.102(d), 485.62 485.727(d), 485.92 491.12(d), 494.62(EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §485.6 §485.68(d), §485.6 §485.920(d), §486 §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)		meetings. A copy of the Fact Sheet is placed at the Reception Desk review from residents and fam at any time. 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; Emergency Preparedness Bin will be reviewed by QAPI at minimum quarterly and as need if 100% threshold is not met, a action plan will be implemented.	vill be ent at I be der eded.

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155670	î ´	UILDING	NSTRUCTION	COMPL 06/10/	ETED
	F PROVIDER OR SUPPLIER			5233 R	ADDRESS, CITY, STATE, ZIP COD DSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Training and testin develop and main preparedness train that is based on the in paragraph (a) or assessment at passection, policies and (b) of this section, plan at paragraph training and testing. The land maintain an extraining and testing the emergency plate of this section, risk (a)(1) of this section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plans this section, risk a (a)(1) of this section. The train must be reviewed annually.	ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years. Seat §483.73(d):] (d) Training LTC facility must develop mergency preparedness g program that is based on an set forth in paragraph (a) c assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least 1483.475(d):] Training and D must develop and gency preparedness training im that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION (X	3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		5233	r address, city, state, zip cod ROSEBUD LANE BURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Training, testing, a dialysis facility multiple emergency prepared and patient orient on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the community of this section. The orientation prograupdated at every and a section or the failed to develop and preparedness training was reviewed and unaccordance with 42 practice could affect a section of Plan on 06/10/24 be with the Executive Director present, the available to show the preparedness training the Emergency Prejenterview at the time Director said the farm program Relias for training and testing she agreed information included in the Emergency This finding was resulted.	wiew and interview, the facility and maintain an emergency and testing program that appdated at least annually in CFR 483.73(d). This deficient et all occupants. The Emergency Preparedness etween 9:45 a.m. and 2:15 p.m. Director and Maintenance ere was no documentation are facility has an emergency and testing program within paredness Plan. Based on the of review, the Executive cility uses the computer Emergency Preparedness Plan for all employees, however, tion for Relias was not ergency Preparedness Plan. Viewed with the Executive of Nursing, and Maintenance	E 0036	E 036 – EP Training and Testing What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially be affected by the alleged deficient practice. The Emergency Preparedness Plan was reviewed and updated with facility specific training and testing information. What measures will be put into	s the

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	NT OF DEFICIENCIES OF CORRECTION			A. BUILDING <u></u>		(X3) DATE SURVEY COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIER		1	5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	place and what systemic chan will be made to ensure that the deficient practice does not recur; All facility staff receive Emerge Preparedness training upon hi and at minimum of annually through RELIAS Learning Onl That information will be rain at updated at minimum of month and placed in the EPP Binder. 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; Emergency Preparedness Bin will be reviewed by QAPI at minimum quarterly and as need if 100% threshold is not met, a action plan will be implemented.	ency ire ine. and ly vill be ent at I be	DATE
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.					

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	OF CORRECTION	IDENTIFICATION NUMBER 155670	A. BUII B. WIN	LDING		COMPL 06/10/	ETED
	PROVIDER OR SUPPLIER			5233 RC	DDRESS, CITY, STATE, ZIP COD DSEBUD LANE RGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements foun Facilities Code, Ni Code. 482.15(e)(3), §483 Emergency gener and LTC facilities] source to power enave a plan for ho	and the CAH] must ency and standby power the emergency plan set (a) of this section. 33.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, did NFPA 110, when a new rewhen an existing	P		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	
	§483.73(g), and C The standards inc this section are ap	§482.15(h), LTC at AHS §485.625(g):] orporated by reference in oproved for incorporation by Director of the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMPLETED 06/10/2024
	PROVIDER OR SUPPLIEI		5233 R	ADDRESS, CITY, STATE, ZIP CO OSEBUD LANE JRGH, IN 47630	DD .
(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 CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	the material from You may inspect Information Reson Boulevard, Baltim Archives and Rec (NARA). For infor this material at Nago to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the char (1) National Fire FBatterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (viii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIEF		5233	ET ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE /BURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON END (X5) DE COMPLETION DATE
	22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 6 2009 Based on record rev failed to implement inspection, testing,	trandard for Emergency and systems, 2010 edition, chapter 7, issued August 6, view and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA	E 0041	E 041 – Hospital CAH and Emergency Power What corrective action(s) waccomplished for those res	vill be
	110, and Life Safet CFR 483.73(e)(2).	y Code in accordance with 42		found to have been affected deficient practice;	d by the
	failed to ensure an a performed for 1 of NFPA 99, Health C Section 6.5.4.1.1.2 Electrical System) g inspected and tested 6.4.4.1.1.3. Section shall be performed	annual fuel quality test was 1 diesel powered generator. Fare Facilities Code, 2012 Edition states Type 2 EES (Essential generator sets shall be 1 in accordance with Section 1 6.4.4.1.1.3 states maintenance in accordance with NFPA 110, gency and Standby Power		No residents experienced a negative outcomes due to talleged deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what correcting action(s) will be taken;	g the the be
	Section 8.3.8 states performed at least a by ASTM standard	ion, Chapter 8. NFPA 110, a fuel quality test shall be unnually using tests approved s. This deficient practice		All residents could potential affected by the alleged defi practice.	cient
	visitors.	dents, as well as staff and		Annual fuel diesel test and obtained.	results
	a.m. and 2:15 p.m. present, there was cand semi-annual ge	view on 06/10/24 between 9:45 with the Maintenance Director locumentation of an annual nerator inspection/service 02/12/24, respectively,		What measures will be put place and what systemic che will be made to ensure that deficient practice does not recur; Annual fuel quality testing with the system of the s	nanges the
	however, there was annual fuel quality	no documentation of an test for the diesel generator		performed and resulted.	
	available for review	during the past 12 month		How the corrective action(s	s) will be

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IT OF DEFICIENCIES	TALL DE OLUBER OLUBRI IER OLUB			
	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/10/2024
		5233 R	ROSEBUD LANE	
(EACH DEFICIEN REGULATORY OR	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)	DATE
review, the Mainten sample was taken do inspection/service of facility's vendor, ho	ance Director said a diesel fuel uring the 08/04/23 annual f the generator by the wever, the facility was not		practice will not recur, i.e., who quality assurance program will put into place;	at Il be
Maintenance Direct inspection vendor d	or contacted the generator uring the survey, but was		will be reviewed by QAPI at minimum quarterly and as need if 100% threshold is not met, a action plan will be implemented.	eded. an
Director, Director o	f Nursing, and Maintenance			
Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/10 Facility Number: 0 Provider Number: 2002 At this Life Safety O Newburgh was four Requirements for Pa Medicare/Medicaid. Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa	as conducted by the Indiana th in accordance with 42 CFR 1/24 11049 155670 258520 Code survey, Majestic Care of ad not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.	K 0000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect July 3, 2024, to the Life Safety Code survey completed on 6/10/2024. We respectfully request a paper review and with provide any additional informat requested.	fic serve s or c cility tive y
	SUMMARY S (EACH DEFICIEN REGULATORY OR period. Based on in review, the Mainten sample was taken do inspection/service of facility's vendor, ho sent a copy of the sa Maintenance Direct inspection vendor do never sent the diese exit. This finding was rev Director, Director of Director during the A Life Safety Code Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/10 Facility Number: 0 Provider Number: AIM Number: 2002 At this Life Safety Of Newburgh was four Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa	PROVIDER OR SUPPLIER IC CARE OF NEWBURGH SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) period. Based on interview at the time of record review, the Maintenance Director said a diesel fuel sample was taken during the 08/04/23 annual inspection/service of the generator by the facility's vendor, however, the facility was not sent a copy of the sample report. Furthermore, the Maintenance Director contacted the generator inspection vendor during the survey, but was never sent the diesel sample report by the time of exit. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	DENTIFICATION NUMBER 155670 ROVIDER OR SUPPLIER C CARE OF NEWBURGH SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION period. Based on interview at the time of record review, the Maintenance Director said a diesel fuel sample was taken during the 08/04/23 annual inspection/service of the generator by the facility's vendor, however, the facility was not sent a copy of the sample report. Furthermore, the Maintenance Director contacted the generator inspection vendor during the survey, but was never sent the diesel sample report by the time of exit. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. K 0000 K 0000	DENTIFICATION NUMBER 155670 ROVIDER OR SUPPLIER IC CARE OF NEWBURGH SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG Deriod. Based on interview at the time of record review, the Maintenance Director said a diesel fuel sample was taken during the 08/04/23 annual inspection/service of the generator by the facility's vendor, however, the facility was not sent a copy of the sample report. Furthermore, the Maintenance Director contacted the generator inspection vendor during the survey, but was never sent the diesel sample report by the time of exit. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. 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). 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). 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). A Life Safety Code Recertification in Medicare/Medicaid, 42 CFR Subpart 483.90(a). A Life Safety Code survey, Majestic Care of Newburgh was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a). Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

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Type V (111) construction and was fully

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	OF CORRECTION	IDENTIFICATION NUMBER 155670	A. BUILDING B. WING	01	COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		5233 R	ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY	
K 0324 SS=F Bldg. 01	sprinklered. The fact with hard wired smospaces open to the cosleeping rooms. The and had a census of the analysis of the cosleeping rooms. The and had a census of the analysis of the cosleeping rooms. The and had a census of the cosleeping rooms. The analysis of the cosleeping rooms. The analysis of the cosleeping rooms. The analysis of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The fact that the cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The cosleeping rooms of the cosleeping rooms of the cosleeping rooms of the cosleeping rooms. The cosleeping rooms of the cosleeping roo	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. orotected according to 8 are not required to be dous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1	K 0324	K 324 Cooking Facilities What corrective action(s) will be accomplished for those reside	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/10/2024	
	ROVIDER OR SUPPLIER		5233 F	CADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE BURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN 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 APPROPRI DEFICIENCY)	DATE
	Ventilation Control Commercial Cooking	chen. NFPA 96, Standard for and Fire Protection of ang Operations, Section 10.5.7		found to have been affected to deficient practice; No residents experienced any	
	states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all residents while in the adjacent dining room.			negative outcomes as a resul the alleged deficient practice.	t of
				How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	e e
				action(s) will be taken; All residents that reside in the	
		ons on 06/10/24 between 2:15 during a tour of the facility with		facility have the potential to be affected by the alleged deficient practice.	
	the Maintenance Di provided with a UL interview with two	rector, the kitchen was 300 hood system. Based on kitchen staff (Kitchen aids), ey would do first if there was		All Dietary Staff will be inserv on proper use of the range ho fire suppression system.	
	hood suppression sy activated, Kitchen a	e range hood and the range /stem had not automatically id #1 said she didn't know. he didn't know. Neither		Head's Electric to install a disconnect switch to the curre cooktop stove/oven on 7/1/24	
	fire suppression sys acknowledged by the time of observation Kitchen aids. The N	y would pull the range hood tem pull station. This was the Maintenance Director at the and interview with the two Maintenance Director said I kitchen staff would be a		What measures will be put int place and what systemic charwill be made to ensure that the deficient practice does not recur;	nges
	priority. This finding was re Director, Director of	viewed with the Executive f Nursing, and Maintenance		All Dietary staff have been inserviced on how to manuall operate the range hood fire suppression system as well a	
	Director during the 3.1-19(b)	exit conference.		manual portable fire extinguishers. Disconnect switch installed or	n the

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		STREE 5233 NEWI		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ration and interview, the	TAG	current cooktop stove/oven.	DATE
	facility failed to ens	sure the cook top for 1 of 1		·	
	shut off at the switch	Physical Therapy area was h when not in use. LSC thin a smoke compartment,		All future Dietary hires will be inserviced during orientation.	
	residential or comm is used to prepare n shall be permitted, facility complies w (1) The space conta is not a sleeping roo (2) The space conta shall be separated f complying with 19. (3) The requiremen	neercial cooking equipment that neals for 30 or fewer persons provided that the cooking ith all the following conditions: ining the cooking equipment		How the corrective action(s) monitored to ensure the deficient practice will not recur, i.e., which quality assurance program with put into place; Inservices will be part of the employee orientation upon his and annually. These records	cient nat ill be ire will
	following is provid (a) A locked switch restricted location, facility that deactiv (b) The switch is us or range whenever supervision. This deficient pract	A switch meeting all the ed: I, or a switch located in a sis provided within the cooking ates the cooktop or range. Sed to deactivate the cooktop the kitchen is not under staff sice could affect at least 5 risitors while in the Physical		be available for review. Quar employee file audits will be completed by the Dietary Manager.	terly
	p.m. and 4:30 p.m. the Maintenance Distove/oven in the Pastove/oven was not observation and the on. Based on intervithe Maintenance Distove/oven was not	ons on 06/10/24 between 2:15 during a tour of the facility with frector, there was a cooktop hysical Therapy area. The being used at the time of power to the stove/oven was view at the time of observation, frector confirmed the cooktop deactivated when not in use, stove/oven in the Physical			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIER		-	5233 R	ADDRESS, CITY, STATE, ZIP COD OSEBUD LANE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
K 0346 SS=F Bldg. 01	switch so Physical power off to the sto This finding was redicted by power off to the sto This finding was redicted by power off to the sto This finding was redicted by preceding the services of the provide of the provided for all passed on record redicted by policy for the protection occupants in the factorial passed on record redicted by policy for the protection occupants in the factorial passed on record redicted by policy for the protection occupants in the factorial passed on record redicted by policy for the protection occupants in the factorial passed on record redicted by policy for the protection occupants in the factorial passed on record reduction procedured by present, the facility documentation, how plan failed to include the protection occupants in the factorial passed on record revaluation, how plan failed to include the provided by present, the facility documentation, how plan failed to include the provided by present the facility documentation, how plan failed to include the provided by present the facility documentation, how plan failed to include the provided by present the facility documentation, how plan failed to include the provided by present the facility documentation in the factorial provided by present the facility documentation, how plan failed to include the provided by present the facility documentation in the factorial provided by present the	n - Out of Service f Service e alarm system is out of than 4 hours in a 24-hour ity having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has service. Tiew and interview, the facility complete and accurate written etion of all occupants es to be followed in the event in has to be placed out of irs or more in a twenty four rdance with LSC, Section ent practice affects all	K 03	346	K 346 Fire Alarm System – Ou Service What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially be	nts y the	07/03/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155670	B. W	ING		06/10/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDERIC DI AN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	an interview at the t	he IDOH Gateway. Based on ime of record review, this was laintenance Director.			affected by the alleged deficient practice.		
	This finding was reviewed with the Executive Director, Director of Nursing and Maintenance Director during the exit conference.				Emergency Preparedness Bin will be updated with the web ling for contacting the Incident Reporting System on the IDOR	nk	
K 0353	3.1-19(b)				What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recur; Department Managers will rev and update Emergency Preparedness Binder quarterly How the corrective action(s) w monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will put into place; Emergency Preparedness Bin will be reviewed by QAPI at minimum quarterly and as need if % threshold is not met, an action plan will be implemented.	ges e iew /. ill be ent at l be der	
SS=F Bldg. 01	Sprinkler System Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 B. WING		COMPLETED	
		155670	B. W.	ING		06/10/	2024
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	REGULATORY OF Records of syster inspection and test secure location are a) Date sprinkler. b) Who provided c) Water system. Provide in REMAI coverage for any automatic sprinkler 9.7.5, 9.7.7, 9.7.8 Based on record record record for the system and found to have a most recent five years. NFPA 25, Standard and Maintenance of Systems, 2011 Edit inspection of piping shall be conducted flushing connection removing a sprinkle line for the purpose of foreign organic at Alternative nondest shall be permitted. The required to be inspection, test and inspection, test and inspection, test and	R LSC IDENTIFYING INFORMATION In design, maintenance, sting are maintained in a not readily available. It system last checked I system test Supply source RKS information on non-required or partial er system.	K 0	TAG	K 353 Sprinkler System - Maintenance and Testing What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; No resider experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential be affected by the same defic practice will be identified and corrective action(s) will be taken; All residents could potentially be affected by the alleged deficient practice. Pipe flush quotes have been obtain and a provider has been select and scheduled for service on 29, 2024. What measures will put into place and what syster changes will be made to ensure	be ents y the ents to ient what ened cted July be mic	
	a qualified contract (Annex A and E are	fied maintenance personnel or or. e not a part of the NFPA e included for informational			that the deficient practice doe recur; Director or will maintai and review service records quarterly to ensure complianc. This will be reviewed quarterly	n e.	
	i redunements but at	e meraucu ivi imvillativilai			i iliis wiii de reviewed duallell	/ LJV	

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155670	B. W	ING		06/10	/2024
			1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8					
МД ІЕСТ	IC CARE OF NEWE	RURCH	5233 ROSEBUD LANE NEWBURGH, IN 47630				
IVIAJEST	OAKE OF NEWE			INCANDO	, in 47000		_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF C			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	purposes only.)				IDT during QAPI. How the		
					corrective action(s) will be		
		25 indicates an obstruction			monitored to ensure the defici-		
	_	eveals the presence of rust or			practice will not recur, i.e., who		
	scale in the sprinkler system as a "critical				quality assurance program wil	l be	
	deficiency".				put into place; Maintenance		
					records will be added to QAPI	to	
	Annex A.4.1.4 indicates critical deficiencies need				be reviewed quarterly by the		
		timely fashion. The fire			committee.		
	1 -	s still capable of performing,					
	but its performance can be impacted, and the						
	implementation of impairment procedures might						
	not be needed.						
	G .: 421	1 1 11 1 1 0 11					
		records shall be made for all					
	_	nd maintenance of the system					
	_	and shall be made available to					
		g jurisdiction upon request.					
	and visitors.	ice affects all residents, staff,					
	and visitors.						
	Findings include:						
	i mamga meraac.						
	Based on record rev	view on 06/10/24 between 9:45					
		with the Maintenance Director					
		cent five year internal					
	1 ~	y sprinkler piping system was					
	_	0/24. This report indicated only					
	1 ~	Results "Failed" for each of					
		sprinkler piping that was					
		of indicate the severity or					
	_	in the sprinkler pipelines.					
	Based on interview at the time of record review,						
	the Maintenance Director said the facility has						
	received three quotes from three different						
	sprinkler vendors to flush the system and is deciding which vendor quote to accept. The						
	1	dated 04/03/24, 04/23/24, and					
		dor quotes were presented at					
	the time of record re						

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 06/10/2024		
NAME OF	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE			
MAJEST	TIC CARE OF NEW	BURGH	NEWBURGH, IN 47630				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		viewed with the Executive of Nursing, and Maintenance exit conference.					
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Where the sprinkle extent and duration been determined, are inspected and recommendations management or d and the fire depart having jurisdiction the sprinkler systet than 10 hours in a building or portion evacuated or an a provided until the returned to service 18.3.5.1, 19.3.5.1 Based on record reter failed to provide a containing procedu protection of all occur automatic sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprin comply with NFPA for the Inspection, 2	er system is impaired, the on of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where em is out of service for more a 24-hour period, the of the building affected are approved fire watch is sprinkler system has been	K 0354	p paraid="843858373" paraeid="{c91c38b0-000b-4bt 5-5502f97b580c}{163}" >K 35 Sprinkler System – Out of Service What corrective action(s) will accomplished for those reside found to have been affected by deficient practice;	be ents		

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15.5.2 requires nine procedures that the

impairment coordinator shall follow. A.15.5.2 (4)

(b) states a fire watch should consist of trained

personnel who continuously patrol the affected

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No residents experienced any

negative outcomes due to the

alleged deficient practice.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
TAG	area. Ready access ability to promptly important items to othe area, the person for fire, but making protection features routes and alarm sy functioning properly could affect all occurred area. Based on record revalues. Based on record revalues. The facility documentation, how plan failed to include the web link for cord System located on the confirmed by the Market This finding was resulted.	to fire extinguishers and the notify the fire department are consider. During the patrol of should not only be looking sure that the other fire of the building such as egress stems are available and y. This deficient practice apants in the facility. The word of 10/24 between 9:45 with the Maintenance Director did provide fire watch every, it was incomplete. The le contacting the IDOH with attacting the Incident Reporting the IDOH Gateway. Based on time of record review, this was faintenance Director.	TAG	How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially affected by the alleged deficient practice. Emergency Preparedness Birwill be updated with the web I for contacting the Incident Reporting System on the IDO Gateway. What measures will be put interplace and what systemic charwill be made to ensure that the deficient practice does not recur; Department Managers will revand update Emergency Preparedness Binder quarterly How the corrective action(s) when monitored to ensure the deficient practice will not recur, i.e., when quality assurance program will put into place; Emergency Preparedness Birwill be reviewed by QAPI at	be ent der ink H o nges e view y. vill be ient at II be
				minimum quarterly and as neulf % threshold is not met, an action plan will be implemented.	eaea.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670		(X2) MULTIPLE C A. BUILDING B. WING	onstruction ;	(X3) DATE SURVEY COMPLETED 06/10/2024			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.2. Based on record refailed to provide a written fire safety per residents to accurate systems, plus a systems, plus a systems, plus a system presidents to accurate systems, plus a system plus a syste	plan for the protection of all plan for the protection of all plan for the protection of all plan for the protection in the event plan for the protection in the event plan for their duties under the plan, plan is readily available erator or with security. The plan is readily available erator or with security. The plan for the provides for all plan components per plan for the protection of all plan for the protection for the protection of all plan for the protection of all provide for plan that shall provide for the protection of all plan for the protection of all provides for the protection of all plan for the protection of all provides for the protection of all plan	K 0711	K and Relocation Plan What corrective action(s) will be accomplished for those residen found to have been affected by deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents could potentially be affected by the alleged deficient practice.	ts the		

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corridor shall not be less than 48 inches in clear

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Staff will be educated on where

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/10/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	summary (EACH DEFICIENT REGULATORY OF width where serving patient sleeping roor required width shall equipment provided equipment during a addressed in the writerining program for equipment is limited i. Equipment in use ii. Medical emerger iii. Patient lift and to This deficient pract in the event of an enion Findings include: Based on a review of Action Plan on 06/12:15 p.m. with the following was in a. The plan did add compartment, howe where the smoke bafacility. b. The plan address powered smoke det not equipped with be detectors, only hard are addressable to the Based on interview the Maintenance Di agreed that the Gen identify where the si the facility, and that with battery powere This finding was re Director, Director of	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION g as means of egress from ms. Projections into the be permitted for wheeled if the relocation of wheeled fire or similar emergency is itten fire safety plan and rethe facility. The wheeled if to: and carts in use recy equipment not in use ransport equipment fice could affect all occupants intergency. of the facility's General Fire 0/24 between 9:45 a.m. and Maintenance Director present, oted: ress evacuation of the smoke ver, the plan did not identify rriers were located in the sed staff response to battery fectors, however, the facility is attery powered smoke wired smoke detectors that the fire alarm control panel. at the time of record review, rector acknowledged and feral Fire Action Plan did not moke barriers were located in the facility was not equipped d smoke detectors. wiewed with the Executive f Nursing, and Maintenance			nder ke to nges ne will be ient nat ill be ime gnee.		
	Director during the	exit conference.					

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED	
		155670	B. W	NG		06/10/	/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	t			OSEBUD LANE			
MAJEST	IC CARE OF NEW	BURGH			JRGH, IN 47630			
	Г		1		T			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION	
TAG	3.1-19(b)	R LSC IDENTIFYING INFORMATION	+	TAG	BLITCHNOT		DATE	
	3.1-17(0)							
K 0712	NFPA 101							
SS=C	Fire Drills							
Bldg. 01	Fire Drills							
5		the transmission of a fire						
		simulation of emergency fire						
	_	ills are held at expected						
		mes under varying						
		et quarterly on each shift.						
		r with procedures and is						
		re part of established						
		ills are conducted between						
	9:00 PM and 6:00							
		ay be used instead of						
	audible alarms.	,						
	19.7.1.4 through 1	19.7.1.7						
		view and interview, the facility	K 0712		K 712 Fire Drills		07/03/2024	
	failed to ensure fire	drills were held on varied			What corrective action(s) will be			
	dates for all shifts a	nd quarters. This deficient			accomplished for those residents			
	practice could affec	t all residents in the facility.			found to have been affected by the			
					deficient practice;			
	Findings include:							
					No residents experienced any			
		the facility's fire drill reports			negative outcomes due to the			
		n 9:30 a.m. and 12:45 p.m. with			alleged deficient practice.			
		rector present, 11 of 12 fire						
		ring the past 12 month period			How other residents having th			
		e last three days of each			potential to be affected by the			
		nterview at the time of record			same deficient practice will be	<i>!</i>		
		nance Director acknowledged			identified and what corrective			
		drills conducted during the			action(s) will be taken;			
	past 12 month period and agreed they were not varied enough by date. This finding was reviewed with the Executive							
					All residents could potentially			
					affected by the alleged deficie	nt		
					practice.			
		f Nursing, and Maintenance						
	Director during the	exit conference.			Fire drills will be conducted wi			
	2.1.10/13				more variation to times and da			
	3.1-19(b)		- 1		with at least half of the monthl	У	I	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/10/2024
	PROVIDER OR SUPPLIER		5233 F	ADDRESS, CITY, STATE, ZIP COD ROSEBUD LANE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	3.1-51(c)			drills being performed between midnight and noon and varie throughout the month.	
				What measures will be put in place and what systemic cha will be made to ensure that the deficient practice does not recur;	nges
				Director or will perform more drills during evenings, overni and weekends at various tim during the month.	ghts
				How the corrective action(s) monitored to ensure the defice practice will not recur, i.e., which is a surance program when the put into place;	cient hat
				Emergency Preparedness Bi will be reviewed by QAPI at minimum quarterly and as ne If % threshold is not met, an action plan will be implement	eeded.
K 0918 SS=F Bldg. 01	Electrical Systems System Maintena The generator or source and assoc of supplying servi- 10-second criteric monthly test, a pro- annually confirm t	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the on is not met during the ocess shall be provided to his capability for the life branches. Maintenance			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155670		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 06/10/2024			
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	and testing of the switches are performed for 1 of NFPA 111, 700.1 Based on record refailed to ensure an performed for 1 of NFPA 99, Health C Section 6.5.4.1.1.2 Electrical System) inspected and tester (5.4.4.1.1.3. Section 8.3.8 states states are performed for Edit of the switches and the switches are programed for 1 of NFPA 99, Health C Section 6.5.4.1.1.2 Electrical System) inspected and tester (6.4.4.1.1.3. Section 8.3.8 states	generator and transfer ormed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised onths for 4 continuous hours. Indeed cold start and utility and transfer of all EES inducted by competent enance and testing of stored arces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels tarked, readily identifiable, an normal power circuits. In ssibility of damage of the resource is a design the new installations. (NFPA 99), NFPA 110,	K 0918	K 918 Electrical Systems – Essential Electrical Systems What corrective action(s) will accomplished for those reside found to have been affected to deficient practice; No residents experienced and negative outcomes due to the alleged deficient practice. How other residents having the potential to be affected by the	ents by the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPL	COMPLETED	
		155670	B. W	B. WING		06/10/	06/10/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIE	R			OSEBUD LANE			
MAJEST	IC CARE OF NEW	BURGH		NEWBURGH, IN 47630				
				INEWBO				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		s. This deficient practice			same deficient practice will be			
		idents, as well as staff and			identified and what corrective			
	visitors.				action(s) will be taken;			
	Findings include:				All residents could potentially			
					affected by the alleged deficie	nt		
		view on 06/10/24 between 9:45			practice.			
		with the Maintenance Director						
	l *	documentation of an annual			New fuel sample analysis take	en.		
		enerator inspection/service			Results pending.			
	dated 08/04/23 and 02/12/24, respectively,							
	however, there was no documentation of an annual fuel quality test for the diesel generator available for review during the past 12 month				What measures will be put into			
					place and what systemic chan	-		
					will be made to ensure that the	9		
	1 ~	nterview at the time of record			deficient practice does not			
		nance Director said a diesel fuel during the 08/04/23 annual			recur;			
	1 -	of the generator by the			Continue appual fuel quality to	ot		
	_	owever, the facility was not			Continue annual fuel quality to for the facility generator and	:51		
	· ·	sample report. Furthermore, the			follow-up to ensure results are			
		tor contacted the generator			received.	•		
		during the survey, but was			received.			
	_	el sample report by the time of			How the corrective action(s) w	ill he		
	exit.	or sumpre repervely and anno er			monitored to ensure the defici			
					practice will not recur, i.e., who			
	This finding was re	eviewed with the Executive			quality assurance program wil			
	_	of Nursing, and Maintenance			put into place;			
	Director during the	_			[
					Director or will schedule testir	ng		
	3.1-19(b)				and follow-up during quarterly	•		
					QAPI meetings.			
K 0923	NFPA 101							
SS=E	Gas Equipment -	Cylinder and Container						
Bldg. 01	Storag							
		Cylinder and Container						
	Storage							
	Greater than or e	qual to 3,000 cubic feet						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155670	(X2) MUI A. BUI B. WIN	LDING			(X3) DATE SURVEY COMPLETED 06/10/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NEWBURGH				STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	(X5) COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE		
TAG	Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 constructions and storage locations enclosure or within space of non- or liconstruction, with that can be secured with flamm from combustibles sprinklered) or enconcombustible cominimum 1/2 hr. fit Less than or equal in a single smoke cylinders available patient care areas of less than or equivalent care	are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and are separated as by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating. If to 300 cubic feet compartment, individual are for immediate use in a with an aggregate volume and to 300 cubic feet are not red in an enclosure. In handled with precautions 6.2. In a cylinder storage are oxigin includes the wording as a fion: OXIDIZING GAS(ES)		TAG	DEFICIENCY)		DATE		
	from full cylinders	ylinders are segregated When facility employs							
	threshold pressure established. Emp avoid confusion. C are protected from	gral pressure gauge, a e considered empty is ty cylinders are marked to Cylinders stored in the open n weather. 3.3, 11.3.4, 11.6.5 (NFPA							
	Based on observation	on and interview, the facility inders of nonflammable gases	K 09	23	K 923 Gas Equipment – Cylind and Container Storage	ler	07/03/2024		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155670 B. WING 06/10/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5233 ROSEBUD LANE MAJESTIC CARE OF NEWBURGH NEWBURGH, IN 47630 (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 such as oxygen were properly secured from falling What corrective action(s) will be in 2 of 64 resident rooms. NFPA 99, Health Care accomplished for those residents Facilities Code, 2012 Edition, Section 11.3.3 states found to have been affected by the storage for nonflammable gases with a total deficient practice; volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 No residents experienced any and 11.3.3.2. NFPA 99, Section 11.3.3.2 states negative outcomes due to the precautions in handling cylinders specified in alleged deficient practice. 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be How other residents having the properly chained or supported in a proper cylinder potential to be affected by the stand or cart. This deficient practice could affect same deficient practice will be at least 35 residents, staff, and visitors in the west identified and what corrective unit. action(s) will be taken; Findings include: All residents could potentially be affected by the alleged deficient Based on observations on 06/10/24 between 2:15 practice. p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was Education for all staff regarding noted: correct usage/storage of oxygen a. There were two medium sized oxygen cylinders cylinders. freestanding on the floor in resident room 126. b. There was one medium sized oxygen cylinder What measures will be put into freestanding on the floor in resident room 117. place and what systemic changes The three oxygen cylinders were not supported in will be made to ensure that the a proper cylinder stand or otherwise secured from deficient practice does not falling. Based on interview at the time of each recur: observation, the Maintenance Director acknowledged the three oxygen cylinders All staff will be inserviced on freestanding on the floor and not supported in a correct usage/storage of oxygen cylinder stand or otherwise secured from falling. cylinders. All oxygen cylinders will be used and stored in a safe This finding was reviewed with the Executive manner. Director, Director of Nursing, and Maintenance Director during the exit conference. How the corrective action(s) will be monitored to ensure the deficient 3.1-19(b) practice will not recur, i.e., what quality assurance program will be

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put into place;

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/05/2024 FORM APPROVED OMB NO. 0938-039

CINID NO. 0750-037									
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED				
1:		155670	B. WING		06/10/2024				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5233 ROSEBUD LANE NEWBURGH, IN 47630						
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE			
				QAPI tool Room Rounds will butilized daily x4 weeks, weekly weeks, monthly x 4 months for Oxygen storage. If 100% thres is not met, an action plan will bimplemented.	/ x4 r shold				

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