STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155670	A. BUILDING -- B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/10/24 Facility Number: 011049 Provider Number: 155670 AIM Number: 200258520 At this Emergency Preparedness survey, Majestic Care of Newburgh was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 104 certified beds. At the time of the survey, the census was 97. Quality Review completed on 06/13/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 3, 2024, to the Life Safety Code survey completed on 6/10/2024. We respectfully request a paper review and will provide any additional information requested.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 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

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical 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 address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary			

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	storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: 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, the plan provided did not address food, water, medical, and pharmaceutical supplies to protect residents health and safety in an emergency, furthermore, the plan provided did not address emergency power to maintain temperatures to protect resident health and safety. Based on interview at the time of record review, the Executive Director and Maintenance Director confirmed the plan provided did not address the previously mentioned items. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.	E 0015	E 015 Subsistence needs for Staff and Patients What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Emergency Preparedness Plan updated with provisions of subsistence needs for staff and residents in the event of evacuation or the need to shelter in place, including company names and phone numbers. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Emergency Water, Emergency Food, Emergency Oxygen, Emergency Resident supplies, including pharmacy, Policies updated in the Emergency Preparedness Plan. How the corrective action(s) will be monitored to ensure the	07/03/2024

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; The Emergency Preparedness Binder will be reviewed quarterly by committee. If % threshold is not met, an action plan will be implemented.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [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 paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other			

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	location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with			

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	external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: 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, there was a policy to track residents and staff during an emergency, however, it was a generic policy. There were no facility specific procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency available for review. Based on interview at the time of record review, the Executive Director and Maintenance Director	E 0018	E 018 – Procedures for Tracking of Staff and Patients What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Staff and Resident Tracking forms will be placed in the Emergency Preparedness Binder. What measures will be put into	07/03/2024

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	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 Director during the exit conference.		place and what systemic changes will be made to ensure that the deficient practice does not recur; Emergency Preparedness Resident and Staff Tracking Policy and Resident and Staff Tracking Forms placed in the Emergency Preparedness binder. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	
E 0020 SS=F Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based			

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	on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of			

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	the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: 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, there was an evacuation plan within the Emergency Preparedness Plan, however, it was a generic plan and not facility specific. Based on interview at the time of record review, the Executive Director and Maintenance Director acknowledged the evacuation plan within the Emergency Preparedness Plan was a generic plan and not facility specific. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.	E 0020	E 020 – Policies for Evacuation and Primary/Alternate Communications What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Facility specific plans will be put in place. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Evacuation policy updated with facility specific information.	07/03/2024

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			Evacuation maps updated with fire door locations and onsite evacuation locations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented.	
E 0023 SS=F Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [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 paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include:	E 0023	E 023 – Policies and Procedures for Medical Documentation What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice. How other residents having the	07/03/2024

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	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, policies and procedure that included a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records was not available for review within the Emergency Preparedness Plan. Based on interview at the time of record review, the Executive Director said the facility uses the computer program E-MAR for a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records, however, it is not addressed in the Emergency Preparedness Plan. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		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. Education for all staff regarding correct usage/storage of oxygen cylinders. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Communication policy updated to include HIPAA compliant resident information sharing to medical information and the availability of records. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented.	

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E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [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 paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING -- B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: 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, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Executive Director confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.	E 0024	E 024 – Policy and Procedures – Volunteers and Staffing What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Policy and Procedure addressing the use of volunteers or other emergency staffing strategies to address surge needs during an emergency. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	07/03/2024

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			Emergency Preparedness Emergency Staffing policy updated and facility specific. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (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]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies	E 0029	E 029 – Development of Communication Plan What corrective action(s) will be	07/03/2024

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	with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: 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, the facility's Emergency Preparedness Plan did include a Communication Plan, however, the Communication Plan was a generic plan and not specific to the facility. Based on interview at the time of review, the Executive Director and Maintenance Director agreed the Communication Plan within the Emergency Preparedness Plan was a generic plan and not specific to the facility. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		accomplished for those residents found to have been affected by the 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. Communication Plan reviewed and updated with facility specific information. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Emergency Communication Plan updated to reflect facility specific communication information. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder	

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			will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	
E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility	E 0032	E 032 – Primary/Alternate Means	07/03/2024

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	155670	A. BUILDING -- B. WING	06/10/2024

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	lacked an emergency preparedness communication program that included (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c)(3). This deficient practice could affect all occupants. Finding include: 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, the plan did not include a communication program that included a primary and an alternate means for communication. Based on interview at the time of record review the Executive Director and Maintenance Director agreed the facility does not have a program for primary and alternative means for communication. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		of Communication What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Communication Plan reviewed and updated with facility specific information. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Emergency Communication Plan updated to reflect primary and alternate means of communication How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;	

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			Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	
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), §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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	release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility lacked an emergency preparedness 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 client 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 as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include:	E 0033	E 033 – Methods for Sharing Information What corrective action(s) will be accomplished for those residents found to have been affected by the 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;	07/03/2024

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	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 medical documentation for residents under the LTC facility's care. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		All residents could potentially be affected by the alleged deficient practice. Reviewed and updated policy and procedure addressing methods for sharing information and medical documentation with other health care providers to maintain continuity of care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Emergency Communication Plan updated with specific methods of sharing information and medical documentation for with other health care providers to ensure continuity of care. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	

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E 0034 SS=F Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the facility	E 0034	E 034 – Information on	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING -- B. WING	06/10/2024

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	lacked an emergency preparedness communication program that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: 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, within the generic communication plan there was no means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7) available for review. Based on interview at the time of record review the Executive Director and Maintenance Director agreed that there was nothing within the generic communication plan to include the aforementioned occupancy, needs, and ability to provide assistance to the AHJ, IC, or designee. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		Occupancy/Needs What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Update communication policy and procedure addressing a means of providing information about the facility's occupancy, needs, and ability to . What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Emergency Communication Plan updated to reflect facility specific policy and procedure addressing a means of providing information about the facility's occupancy, needs and ability to . How the corrective action(s) will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented	
E 0035 SS=F Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility lacked an emergency preparedness	E 0035	E 035 – LTC and ICF/IID Sharing Plan with Patients	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	communication program that included a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: 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, within the generic communication plan there was no method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview at the time of record review, the Executive Director and Maintenance Director agreed that no documentation or program has been created or shared. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		What corrective action(s) will be accomplished for those residents found to have been affected by the 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 Communication plan was reviewed and updated to include facility specific information for sharing information with the residents and families regarding the Emergency Preparedness Plan. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All residents and responsible parties issued the Resident and Family Notification Fact Sheet. The Fact Sheet will be issued at admission and at minimum annually during resident council	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155670	A. BUILDING -- B. WING	06/10/2024

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			meetings. A copy of the Fact Sheet is placed at the Reception Desk for review from residents and families at any time. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at			

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	§486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).			

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	*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: 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, there was no documentation available to show the facility has an emergency preparedness training and testing program within the Emergency Preparedness Plan. Based on interview at the time of review, the Executive Director said the facility uses the computer program Relias for Emergency Preparedness Plan training and testing for all employees, however, she agreed information for Relias was not included in the Emergency Preparedness Plan. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.	E 0036	E 036 – EP Training and Testing What corrective action(s) will be accomplished for those residents found to have been affected by the 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	07/03/2024

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			place and what systemic changes will be made to ensure that the deficient practice does not recur; All facility staff receive Emergency Preparedness training upon hire and at minimum of annually through RELIAS Learning Online. That information will be rain and updated at minimum of monthly and placed in the EPP Binder. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Maintenance Director present, there was documentation of an annual and semi-annual generator inspection/service 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	E 0041	E 041 – Hospital CAH and LTC Emergency Power What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Annual fuel diesel test and results obtained. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Annual fuel quality testing will be performed and resulted. How the corrective action(s) will be	07/03/2024

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	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.		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If 100% threshold is not met, an action plan will be implemented.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/10/24 Facility Number: 011049 Provider Number: 155670 AIM Number: 200258520 At this 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 from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 3, 2024, to the Life Safety Code survey completed on 6/10/2024. We respectfully request a paper review and will provide any additional information requested.	

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	sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 104 and had a census of 97 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/13/24			
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression	K 0324	K 324 Cooking Facilities What corrective action(s) will be accomplished for those residents	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 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. Findings include: Based on observations on 06/10/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the kitchen was provided with a UL 300 hood system. Based on interview with two kitchen staff (Kitchen aids), when asked what they would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, Kitchen aid #1 said she didn't know. Kitchen aid #2 said he didn't know. Neither kitchen aid said they would pull the range hood fire suppression system pull station. This was acknowledged by the Maintenance Director at the time of observation and interview with the two Kitchen aids. The Maintenance Director said more training for all kitchen staff would be a priority. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; No residents experienced any negative outcomes as a result of 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 that reside in the facility have the potential to be affected by the alleged deficient practice. All Dietary Staff will be inserviced on proper use of the range hood fire suppression system. Head's Electric to install a disconnect switch to the current cooktop stove/oven on 7/1/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All Dietary staff have been inserviced on how to manually operate the range hood fire suppression system as well as manual portable fire extinguishers. Disconnect switch installed on the	

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	2. Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stove/ovens in the Physical Therapy area was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least 5 resident, staff and visitors while in the Physical Therapy area. Findings include: Based on observations on 06/10/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there was a cooktop stove/oven in the Physical Therapy area. The stove/oven was not being used at the time of observation and the power to the stove/oven was on. Based on interview at the time of observation, the Maintenance Director confirmed the cooktop stove/oven was not deactivated when not in use, and further said the stove/oven in the Physical		current cooktop stove/oven. All future Dietary hires will be inserviced during orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Inservices will be part of the employee orientation upon hire and annually. These records will be available for review. Quarterly employee file audits will be completed by the Dietary Manager.	

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	Therapy area was not equipped with a disconnect switch so Physical Therapy staff could shut the power off to the stove/oven when not in use. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete and accurate written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Maintenance Director present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include contacting the IDOH with the web link for contacting the Incident Reporting	K 0346	K 346 Fire Alarm System – Out of Service What corrective action(s) will be accomplished for those residents found to have been affected by the 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	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 01 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

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	System located on the IDOH Gateway. Based on an interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director, Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		affected by the alleged deficient practice. Emergency Preparedness Binder will be updated with the web link for contacting the Incident Reporting System on the IDOH Gateway. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Department Managers will review and update Emergency Preparedness Binder quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	155670	A. BUILDING 01 B. WING	06/10/2024

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure action was initiated after 1 of 1 automatic sprinkler piping system was inspected and found to have material buildup during the most recent five year internal pipe inspection. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. (Annex A and E are not a part of the NFPA requirements but are included for informational	K 0353	K 353 Sprinkler System - Maintenance and Testing What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Pipe flush quotes have been obtained and a provider has been selected and scheduled for service on July 29, 2024. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Director or will maintain and review service records quarterly to ensure compliance. This will be reviewed quarterly by	07/30/2024

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	155670	A. BUILDING 01 B. WING	06/10/2024

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	purposes only.) Annex E of NFPA 25 indicates an obstruction investigation that reveals the presence of rust or scale in the sprinkler system as a "critical deficiency". Annex A.4.1.4 indicates critical deficiencies need to be corrected in a timely fashion. The fire protection system is still capable of performing, but its performance can be impacted, and the implementation of impairment procedures might not be needed. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff, and visitors. Findings include: Based on record review on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Maintenance Director present, the most recent five year internal inspection of the dry sprinkler piping system was performed on 02/20/24. This report indicated only that the Inspection Results "Failed" for each of the two sections of sprinkler piping that was inspected. It did not indicate the severity or amount of buildup 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 vendor quotes were dated 04/03/24, 04/23/24, and 05/14/24. The vendor quotes were presented at the time of record review.		IDT during QAPI. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Maintenance records will be added to QAPI to be reviewed quarterly by the committee.	

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	155670	A. BUILDING 01 B. WING	06/10/2024

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	This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 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	K 0354	p paraid="843858373" paraeid="{c91c38b0-000b-4bfb-8b25-5502f97b580c}{163}" >K 354 Sprinkler System – Out of Service What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents experienced any negative outcomes due to the alleged deficient practice.	07/03/2024

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	155670	A. BUILDING 01 B. WING	06/10/2024

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	area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Maintenance Director present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Executive Director, Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		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. Emergency Preparedness Binder will be updated with the web link for contacting the Incident Reporting System on the IDOH Gateway. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Department Managers will review and update Emergency Preparedness Binder quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	

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	155670	A. BUILDING 01 B. WING	06/10/2024

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K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear	K 0711	K and Relocation Plan What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Staff will be educated on where	07/03/2024

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	width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's General Fire Action Plan on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Maintenance Director present, the following was noted: a. The plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility. b. The plan addressed staff response to battery powered smoke detectors, however, the facility is not equipped with battery powered smoke detectors, only hard wired smoke detectors that are addressable to the fire alarm control panel. Based on interview at the time of record review, the Maintenance Director acknowledged and agreed that the General Fire Action Plan did not identify where the smoke barriers were located in the facility, and that the facility was not equipped with battery powered smoke detectors. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference.		smoke barriers are within the building. Emergency Preparedness Binder updated with the location of smoke barriers, how the smoke detection system and control panels work. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Building plan/emergency evacuation maps will display smoke barriers and routes of egress on each hall/area of the building. All staff will be inserviced on where smoke barriers are located and how the smoke detection system and control panels function. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All staff will be inserviced at time of hire and annually by Maintenance Director or designee. Inservice records will be kept and be available for review.	

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	155670	A. BUILDING 01 B. WING	06/10/2024

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K 0712 SS=C Bldg. 01	3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held on varied dates for all shifts and quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/12/24 between 9:30 a.m. and 12:45 p.m. with the Maintenance Director present, 11 of 12 fire drills conducted during the past 12 month period were held during the last three days of each month. Based on interview at the time of record review, the Maintenance Director acknowledged the dates of all fire drills conducted during the past 12 month period and agreed they were not varied enough by date. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. 3.1-19(b)	K 0712	K 712 Fire Drills What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Fire drills will be conducted with more variation to times and dates with at least half of the monthly	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 01 B. WING	06/10/2024

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	3.1-51(c)		drills being performed between midnight and noon and varied throughout the month. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Director or will perform more fire drills during evenings, overnights and weekends at various times during the month. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Emergency Preparedness Binder will be reviewed by QAPI at minimum quarterly and as needed. If % threshold is not met, an action plan will be implemented.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

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	155670	A. BUILDING 01 B. WING	06/10/2024

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	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved	K 0918	K 918 Electrical Systems – Essential Electrical Systems What corrective action(s) will be accomplished for those residents found to have been affected by the 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	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 01 B. WING	06/10/2024

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MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

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	by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 06/10/24 between 9:45 a.m. and 2:15 p.m. with the Maintenance Director present, there was documentation of an annual and semi-annual generator inspection/service 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 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. 3.1-19(b)		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. New fuel sample analysis taken. Results pending. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Continue annual fuel quality test for the facility generator and follow-up to ensure results are received. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director or will schedule testing and follow-up during quarterly QAPI meetings.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet			

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	155670	A. BUILDING 01 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases	K 0923	K 923 Gas Equipment – Cylinder and Container Storage	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 01 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	such as oxygen were properly secured from falling in 2 of 64 resident rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect at least 35 residents, staff, and visitors in the west unit. Findings include: Based on observations on 06/10/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There were two medium sized oxygen cylinders freestanding on the floor in resident room 126. b. There was one medium sized oxygen cylinder freestanding on the floor in resident room 117. The three oxygen cylinders were not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of each observation, the Maintenance Director acknowledged the three oxygen cylinders freestanding on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Executive Director, Director of Nursing, and Maintenance Director during the exit conference. 3.1-19(b)		What corrective action(s) will be accomplished for those residents found to have been affected by the 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. Education for all staff regarding correct usage/storage of oxygen cylinders. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be inserviced on correct usage/storage of oxygen cylinders. All oxygen cylinders will be used and stored in a safe manner. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;	

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			QAPI tool Room Rounds will be utilized daily x4 weeks, weekly x4 weeks, monthly x 4 months for Oxygen storage. If 100% threshold is not met, an action plan will be implemented.	