CENTERS FOR	C MEDICARE & MEDIC				ONID NO. 0936-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED
		155358	B. WING		07/08/2024
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD OPLAR ST	
MAJEST	IC CARE OF DEMI	NG PARK	TERRE	HAUTE, IN 47803	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.		E 0000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We res	fic
	Survey Date: 07/08			the right to contest the finding allegations as part of any	<b>I</b>
	Facility Number: 0			proceedings and submit these	·
	Provider Number:	155358		responses pursuant to our	
	AIM Number: 100	cility ction			
	At this Emergency Preparedness survey, Majestic			be considered our allegation of	
	Care of Deming Par	rk was found not in compliance		compliance effective 7/29/24 t	
	_	eparedness Requirements for		life safety survey completed o	
		caid Participating Providers		7/8/24. We respectfully reque	
	and Suppliers, 42 C			paper review and will provide additional information request	any
	The facility has 86	certified beds. At the time of		additional information request	cu.
	the survey, the cens				
	-	npleted on 07/10/24			
E 0004 SS=F Bldg	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).  The [facility] must comply with all applicable Federal, State and local emergency				
	Federal, State and	d local emergency			

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

(X6) DATE

TITLE

Pamela Clevenger Executive Director/HFA 08/01/2024

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

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	OF CORRECTION	IDENTIFICATION NUMBER  155358	· ′	ILDING	INSTRUCTION	COMPL 07/08/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3300 POPLAR ST  TERRE HAUTE, IN 47803					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſE	(X5) COMPLETION DATE	
	must develop esta comprehensive er program that mee section. The emer program must incl the following elem (a) Emergency Pladevelop and main preparedness plar and updated at lea must do all of the * [For hospitals at §485.625(a):] Emergency Planust develop and main preparedness required comprehensive er program that mee section, utilizing a * [For LTC Facilities Emergency Planust develop and main preparedness plar and updated at lease the section of th	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency uirements. The [hospital or op and maintain a mergency preparedness is the requirements of this in all-hazards approach.  es at §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually.  ities at §494.62(a):]  The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years.						
	failed to develop an	view and interview, the facility and maintain an emergency hat was reviewed and updated	E 00	004	="" p=""> ="" p="">		07/29/2024	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	ESURVEY LETED B/2024
	PROVIDER OR SUPPLIER		3300 F	ADDRESS, CITY, STATE, ZIP COPLAR ST E HAUTE, IN 47803	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION accordance with 42 CFR	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE A DEFICIENCY)  ="" p="">	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE
	1	cient practice could affect all		="" p=""> It is the policy of this fa review the Emergency Management Plan ann	ually.	
	Preparedness Plan of the Maintenance Differ an updated emereviewed by the fact twelve-month period The emergency plan reviewed within the interview at the tim Maintenance Direct emergency prepared annual review and updated the property of the maintenance of the maintenance Direct emergency prepared annual review and updated the maintenance of the mainte	view of the facility's Emergency on 07/08/24 at 12:30 p.m. with rector present, documentation regency preparedness program ility within the most recent d was not available for review. In available had not been to past 12 months. Based on the of record review, the tor confirmed that the dness plan had not had an apdate as of this survey.  Viewed with the Executive tenance Director at the exit		The corrective action to those residents found to affected by the deficient includes; There are no identified.  How other residents the potential to be affected same defective practice identified and what correction will be taken: All have the potential to be but none identified. The Emergency Operations been updated and place Emergency Manageme. The Emergency Manageme The Emergency Plan were viewed at least annuations task will be entered TELS PM system for most the Administrator and Maintenance Director as in the QAPI process for reviews.  The Administrator will be responsible for monitor compliance. 7.29.24	to be Int practice Int practice Int practice Int practice Interest and have the Interest by the Interest and has been ally, and Into the I	
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.625(a 485.727(a)(1)-(2),	416.54(a)(1)-(2), 418.113(a) )(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) )(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)				

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Event ID:

SSV321

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NAME OF PROVIDER OR SUPPLIER  NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  ISSUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG  PIED BASED ON ALL HAZZAGE RISK ASSESSMENT \$403.748(a)(1)-(2), \$441.194(a)(1)-(2), \$481.113(a)(1)-(2), \$481.113(a)(1)-(2), \$481.113(a)(1)-(2), \$483.475(a)(1)-(2), \$483.47	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
MAJESTIC CARE OF DEMING PARK  (X4) ID  REETX  (RACH DEFICIENCY MUST BE PRECEDED BY PULL  TAG  Plan Based on All Hazards Risk Assessment  \$403.748(a)(1)+(2), \$441.194(a)(1)+(2), \$460.84(a)(1)+(2), \$441.194(a)(1)+(2), \$483.73(a)(1)+(2), \$483.475(a)(1)+(2), \$483.73(a)(1)+(2), \$483.65(a)(1)+(2), \$483.920(a)(1)+(2), \$486.580(a)(1)+(2), \$485.920(a)(1)+(2), \$486.580(a)(1)+(2), \$486.580(a)(1)+(2), \$486.580(a)(1)+(2), \$486.580(a)(1)+(2), \$486.580(a)(1)+(2), \$486.580(a)(1)+(2), \$486.580(a)(1)+(2), \$486.590(a)(1)+(2), \$486.580(a)(1	AND PLAN	OF CORRECTION				<del></del>		
MAJESTIC CARE OF DEMING PARK  (A) ID  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  PARETX TAG  PIAN Based on AI HAZARD'S Risk Assessment §403.748(a)(1)+(2), §416.54(a)(1)+(2), §446.84(a)(1)+(2), §441.54(a)(1)+(2), §446.84(a)(1)+(2), §445.73(a)(1)+(2), §446.84(a)(1)+(2), §445.73(a)(1)+(2), §446.84(a)(1)+(2), §445.73(a)(1)+(2), §446.82(a)(1)-(2), §485.73(a)(1)+(2), §446.82(a)(1)-(2), §485.73(a)(1)+(2), §446.82(a)(1)-(2), §485.82(a)(1)-(2), §446.82(a)(1)-(2), §485.82(a)(1)-(2)  ((a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following.]  (1) Be based on and include a documented, facility-based and community-based risk assessment. utilizing an all-hazards approach.*  (2) Include strategies for addressing emergency events identified by the risk assessment.  *[For Hospices at §418.113(a)] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.  (2) Include strategies for addressing emergency events identified by the risk assessment, utilizing an all-hazards approach.  (2) Include strategies for addressing emergency events identified by the risk assessment, utilizing an all-hazards approach.  (2) Include strategies for addressing emergency events identified by the risk assessment, utilizing an all-hazards approach.  (2) Include strategies for addressing emergency events identified by the risk assessment, utilizing an all-hazards approach.			155358	B. WIN	NG		07/08/	2024
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION PRACTICATORY OR LSC IDENTIFYING INFORMATION  REGILATORY OR LSC IDENTIFYING INFORMATION  AND HAZARDS RISK ASSESSMENT \$403.748(a)(1)-(2), \$416.54(a)(1)-(2), \$416.54(a)(1)-(2), \$441.13(a)(1)-(2), \$441.144(a)(1)-(2), \$483.73(a)(1)-(2), \$443.475(a)(1)-(2), \$483.73(a)(1)-(2), \$485.727(a)(1)-(2), \$485.82(a)(1)-(2), \$485.82(a)(					3300 PC	OPLAR ST		
TAG REGULATORY OR IS DEPARTED IN FOLIA TO THE PRECEDED BY FULL TAG REGULATORY OR IS DEPARTED IN INFORMATION DATE  Plan Based on All Hazards Risk Assessment \$403.748(a)(1)-(2), \$416.54(a)(1)-(2), \$416.54(a)(1)-(2), \$446.04(a)(1)-(2), \$446.04(a)(1)-(2), \$446.04(a)(1)-(2), \$446.04(a)(1)-(2), \$446.04(a)(1)-(2), \$446.04(a)(1)-(2), \$485.625(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.625(a)(1)-(2), \$486.06(a)(1)-(2), \$486.06(a)(a)(1)-(2), \$486.06(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	·	ID	DROVIDEDIC DI AN OF CODDECTION		(X5)
TAG REGULATORY OR ISC IDENTIFYING INFORMATION  Plan Based on All Hazards Risk Assessment \$403.748(a)(1)-(2), \$416.54(a)(1)-(2), \$416.13(a)(1)-(2), \$416.13(a)(1)-(2), \$418.13(a)(1)-(2), \$441.84(a)(1)-(2), \$483.73(a)(1)-(2), \$483.73(a)(1)-(2), \$483.75(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.52(a)(1)-(2), \$485.92(a)(1)-(2), \$495.92(a)(1)-(2), \$495.72(a)(1)-(2), \$495.92(a)(1)-(2),	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	] ]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
\$403.748(a)(1)-(2), \$416.54(a)(1)-(2), \$418.113(a)(1)-(2), \$418.113(a)(1)-(2), \$421.194(a)(1)-(2), \$438.373(a)(1)-(2), \$438.373(a)(1)-(2), \$438.373(a)(1)-(2), \$438.373(a)(1)-(2), \$438.373(a)(1)-(2), \$438.562(a)(1)-(2), \$438.562(a)(1)-(2), \$438.562(a)(1)-(2), \$438.592(a)(1)-(2), \$439.12(a)(1)-(2),	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
the consequences of power failures, natural disasters, and other emergencies that would	TAG	Plan Based on All §403.748(a)(1)-(2) §418.113(a)(1)-(2) §460.84(a)(1)-(2) §483.73(a)(1)-(2) §485.625(a)(1)-(2) §485.920(a)(1)-(2) §491.12(a)(1)-(2), [(a) Emergency Pl develop and main preparedness plar and updated at lear must do the follow (1) Be based on a facility-based and assessment, utilizing approach.*  (2) Include strategemergency events assessment.  * [For Hospices at Plan. The Hospices at Plan. The Hospices at Plan. The Hospices at Plan. The Based on a facility-based and assessment, utilizing approach. (2) Include strategemergency events assessment, utilizing approach. (2) Include strategemergency events assessment, incluit the consequences	Hazards Risk Assessment ), §416.54(a)(1)-(2), ), §441.184(a)(1)-(2), §482.15(a)(1)-(2), ), §483.475(a)(1)-(2), ), §485.68(a)(1)-(2), ), §486.360(a)(1)-(2), §494.62(a)(1)-(2)  Ian. The [facility] must tain an emergency in that must be reviewed, fast every 2 years. The plantain an emergency in the must be reviewed, fast every 2 years. The plantain an all-hazards  gies for addressing is identified by the risk  It §418.113(a):] Emergency is must develop and gency preparedness plantain wed, and updated at least the plan must do the  Indiculde a documented, community-based risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards  gies for addressing is identified by the risk ing an all-hazards		TAG			DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155358		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>-</u>	(X3) DATE SURVEY COMPLETED 07/08/2024	
	ROVIDER OR SUPPLIER		3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST HAUTE, IN 47803	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	*[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lead of the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment.  *[For ICF/IIDs at § Plan. The ICF/IID an emergency prebereviewed, and years. The plan meters of the pl	The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ing missing residents. itse for addressing is identified by the risk and include a documented, community-based risk ing an all-hazards in that must develop and maintain paredness plan that must updated at least every 2 ust do the following:  Ind include a documented, community-based risk ing an all-hazards ing missing clients. It is for addressing is identified by the risk in the missing community-based in the risk in the missing and includes a cy-based and community-based in the missing an all-hazards approach it within the most recent twelve	E 0006	It is the policy of this facility to have a facility/community bas risk assessment utilizing an all-hazards approach which is reviewed on an annual basis.  The corrective action taken to the corrective action to th	ed
	addressing emergenrisk assessment in a 483.73(a) (1) and 42	2) included strategies for cy events identified by the eccordance with 42 CFR 2 CFR 483.73(a) (2). This ould affect all occupants.		those residents found to be affected by the deficient practice includes: There are identified residents What: other residents that h	

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155358		r í	JILDING	INSTRUCTION	COMPL 07/08/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD OPLAR ST		
MAJEST	IC CARE OF DEMIN	NG PARK		TERRE	HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Findings include:				the potential to be affected by the same defective practice will be identified and what	y	
	Manual on 07/08/24 Maintenance Director facility-based and correct assessment reviewer most recent twelver available for review time of record reviewed withing that an all reviewed withing the available to review a This finding were re-	Emergency Preparedness at 12:30 p.m. with the or present, a documented ommunity-based risk d by the facility within the month period was not . Based on interview at the w, the Maintenance Director I hazards risk assessment e last twelve months was not at the time of the survey.  Eviewed with the Executive enance Director during the exit			corrective action will be taken. All residents have the potential to be affected but nor were identified. The Facility Risk-All Hazard Assessment were completed and has been placed the Emergency Management Binder  The Facility Risk-All Hazard Assessment will be reviewed a least annually, and this task will be entered into the TELs system for monitoring by the Administration and Maintenance Director and included in the QAPI process for systems reviews.  Administrator responsible.  Completion Date: 7.29.3	vas ed in at ill em rator	
E 0013 SS=F Bldg	484.102(b), 485.62 485.727(b), 485.92 491.12(b), 494.62( Development of El §403.748(b), §416 §441.184(b), §460 §483.73(b), §483.4 §485.68(b), §485.6 §485.920(b), §486 §494.62(b). (b) Policies and prodevelop and implest preparedness policion the emergency	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 360(b), §491.12(b), 6000000000000000000000000000000000000					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	ľ	UILDING	NSTRUCTION	(X3) DATE COMPI 07/08	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3300 POPLAR ST TERRE HAUTE, IN 47803				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	paragraph (a)(1) c communication pl section. The polic	of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2					
	and procedures. In develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) communication placetion. The police	s at §483.73(b):] Policies The LTC facility must ement emergency icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.					
	*Additional Requir	rements for PACE and					
	procedures. The develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies manager nonmedical emergimited to: Fire; equal failure; care-related disasters likely to safety of the partic.	PACE organization must ement emergency icies and procedures, based or plan set forth in paragraph in risk assessment at post this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be lated at least every 2 years.					
	-	ties at §494.62(b):] Policies The dialysis facility must					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155358		A. BU	A. BUILDING B. WING		COMPLETED 07/08/2024		
	PROVIDER OR SUPPLIEF			3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST E HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	on the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policible reviewed and uppears. These emergency interruption likely to occur in the area.  Based on record revaluated to develop and preparedness policible policies and procedupdated at least and CFR 483.73(b). The all residents in the first the Maintenance Displaced updated policies and facility within the material period was not avaited emergency plan avaitable to the maintenance of the time of record residents. This finding was residents and update as of this thin the first finding was residents.	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 orgencies include, but are equipment or power ted emergencies, water in, and natural disasters in facility's geographic view and interview, the facility in dimplement emergency es and procedures. The ures must be reviewed and anally in accordance with 42 is deficient practice could affect facility.  The facility's Emergency on 07/08/24 at 12:30 p.m. with rector, documentation for diprocedures reviewed by the most recent twelve-month lable for review. The milable had not been reviewed anonths. Based on interview at eview, the Maintenance that the emergency and not had an annual review	E 0	013	It is the policy of this facility to review the Emergency Preparedness policies and procedures on an annual basi The corrective action taken of those residents found to be affected by the deficient practice includes There are residentified residents. What: other residents that he the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but no were identified. The Emergent Policies and Procedures Manual has been reviewed by the QA team and a signature sheet act to the Emergency Management Binder. The Emergency Management Policies and Procedures will be reviewed annually by the QAF Committee, and a signature sheet acts and Procedures will be reviewed annually by the QAF Committee, and a signature sheet.	s. for  no  ave y  ne ncy ual Pl dded nt	07/26/2024

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Event ID:

SSV321 Facility ID: 000249

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIE		330	EET ADDRESS, CITY, STATE, ZIP COD 00 POPLAR ST RRE HAUTE, IN 47803	<b>,</b>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
				will be placed in the Eme Managment Binder once annual review has been completed. This task will entered into the TELs PN for monitoring. Administrator will be resp to monitor compliance. Compliance Date: 7.29.2	the be d system consible
E 0029 SS=F Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §411 §441.184(c), §461 §483.73(c), §485. §485.68(c), §485. §485.920(c), §486. §494.62(c).  (c) The [facility] m an emergency proplan that complied local laws and mulat least every 2 years.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),			
	failed to develop and preparedness common with Federal, State	view and interview, the facility and maintain an emergency nunication plan that complies and local laws in accordance 3(c). This deficient practice upants.	E 0029	It is the policy of this facil and maintain an Emerger Preparedness Plan Communication Plan. The corrective action tal those residents found to affected by the deficient practice includes There	ken for o be
	Based on review of	the facility's Emergency		identified residents What: other residents the	hat have

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	T OF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	ì í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIER			3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST E HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Preparedness Plan of the Maintenance Di updated communicate facility within the number of the period was not avaited emergency plan prowithin the past twelf at the time of record Director confirmed preparedness prograthe facility within the period.	on 07/08/24 at 12:30 p.m. with rector, documentation for an ation plan reviewed by the most recent twelve-month lable for review. The wided had not been reviewed ve months. Based on interview direview, the Maintenance the entire emergency am had not been reviewed by the most recent twelve-month wiewed with the Executive enance Director at the exit			the potential to be affected be the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but not were identified. The Emergen Communication Plan has been reviewed, updated and placed the Emergency Preparedness Binder.  The Emergency Communication plan will be reviewed annually the Emergency Management Preparedness plan by the QAI Committee. The Administrator be responsible for completion. Date: 7.29.24	ne cy n in on with	
E 0037 SS=F Bldg	441.184(d)(1), 482, 483.73(d)(1), 484, 485.68(d)(1), 485, 486.360(d)(1), 491, 485, 486.360(d)(1), 491, 481, 481, 481, 481, 481, 481, 481, 48	am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)					

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at §491.12:]

all of the following:

§485.727, OPOs at §486.360, RHC/FQHCs

(1) Training program. The [facility] must do

(i) Initial training in emergency preparedness

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155358	B. W	ING		07/08/	/2024
NAME OF B	AD CLUBED OD CLUBBLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .		3300 PG	OPLAR ST		
MAJEST	IC CARE OF DEMI	NG PARK		TERRE	HAUTE, IN 47803		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
		edures to all new and viduals providing services					
	-						
	under arrangement, and volunteers, consistent with their expected roles.						
		ency preparedness training					
	at least every 2 ye						
		mentation of all emergency					
	preparedness trai	_					
	(iv) Demonstrate s	_					
	emergency proced						
	, ,	cy preparedness policies					
		re significantly updated, the					
	updated policies a	duct training on the					
	upuateu policies a	ina procedures.					
	*[For Hospices at	§418.113(d):] (1) Training.					
	The hospice must	do all of the following:					
	(i) Initial training ir	n emergency preparedness					
		edures to all new and					
		mployees, and individuals					
		under arrangement,					
	consistent with the						
	(ii) Demonstrate s	•					
	emergency proced	gency preparedness training					
	at least every 2 ye						
		view and rehearse its					
		redness plan with hospice					
		ling nonemployee staff),					
	with special emph	asis placed on carrying out					
	the procedures ne	cessary to protect patients					
	and others.						
	, ,	mentation of all emergency					
	preparedness trai	~					
		ncy preparedness policies					
	•	re significantly updated, the					
		duct training on the					
	updated policies a procedures.	ii iu					
	proocuuros.						

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155358	B. W	ING		07/08/	/2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					OPLAR ST		
MAJEST	IC CARE OF DEMII	NG PARK		TERRE	HAUTE, IN 47803		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCI		DATE
		l41.184(d):] (1) Training FF must do all of the					
	following:	ii must do an or the					
	_	n emergency preparedness					
	policies and procedures to all new and						
	existing staff, individuals providing services						
	under arrangemer	nt, and volunteers,					
	consistent with the	· · · · · · · · · · · · · · · · · · ·					
	, ,	ning, provide emergency					
		ning every 2 years.					
	(iii) Demonstrate s	_					
	emergency proced	mentation of all emergency					
	preparedness trail						
		cy preparedness policies					
	, ,	re significantly updated, the					
		ict training on the updated					
	policies and proce						
	*[For DACE at \$46	20 04/d\:1/4\ The DACE					
	-	60.84(d):] (1) The PACE do all of the following:					
		n emergency preparedness					
	,,	edures to all new and					
		viduals providing on-site					
	•	rangement, contractors,					
	participants, and v	volunteers, consistent with					
	their expected role	es.					
	(ii) Provide emerg	ency preparedness training					
	at least every 2 ye						
	(iii) Demonstrate s	_					
		dures, including informing					
		at to do, where to go, and					
		n case of an emergency. mentation of all training.					
	` '	ncy preparedness policies					
	, ,	re significantly updated, the					
		uct training on the updated					
	policies and proce						
	*[For LTC Facilitie	es at §483.73(d):] (1)					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	JILDING	NSTRUCTION	(X3) DATE COMPI <b>07/08</b>	LETED
	PROVIDER OR SUPPLIER		3300 PC	DDRESS, CITY, STATE, ZIP COD DPLAR ST HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION
TAG	Training Program. of the following: (i) Initial training in policies and proce existing staff, individed arrangement consistent with the state of the following at least annually. (iii) Provide emerging at least annually. (iii) Maintain docurpreparedness train (iv) Demonstrate of the following emergency proced arrowing emergency proced and existing of the following emergency proced in the following emergency plan with the following emergency pla	eir expected role. ency preparedness training mentation of all emergency ning. staff knowledge of dures.  485.68(d):](1) Training. The of the following: raining in emergency cies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's vithin 2 weeks of their first ning program must include ocation and use of alarm als and firefighting  ncy preparedness policies re significantly updated, the uct training on the updated	TAG			DATE

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<del></del>	COMPL	
		155358	B. WI	NG		07/08/	2024
NAME OF P	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD		
					OPLAR ST		
MAJESTIC CARE OF DEMING PARK			TERRE	HAUTE, IN 47803			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	following:						
		n emergency preparedness					
		edures, including prompt					
	reporting and exti						
	•	nere necessary, evacuation nnel, and guests, fire					
		ooperation with firefighting					
	•	orities, to all new and					
		viduals providing services					
	under arrangemer						
	consistent with the						
		ency preparedness training					
	at least every 2 ye						
		mentation of the training.					
	(iv) Demonstrate	_					
	emergency proced	_					
		ncy preparedness policies					
	, ,	re significantly updated, the					
		et training on the updated					
	policies and proce	-					
	#F 01410 10	405 000( I) 1 (4) T : :					
	-	485.920(d):] (1) Training.					
	-	orovide initial training in					
		redness policies and					
		new and existing staff,					
	individuals providi	9					
	-	volunteers, consistent with					
	their expected role						
		the training. The CMHC					
		staff knowledge of					
	CMHC must provi	dures. Thereafter, the					
	·	ning at least every 2 years.					
		view and interview, the facility	E 00	37	It is the policy of this facility to		07/29/2024
		nual training for the		, , , ,	ensure that all newly hired		011271202 <del>1</del>
		dness Program (EPP). The LTC			employees receive training on		
		of the following: (i) Initial			emergency preparedness and		
	•	cy preparedness policies and			other employees receive annu		
		w and existing staff,			training on emergency	•	
	-	ng services under arrangement,			preparedness. Training		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358		JILDING	NSTRUCTION	(X3) DATE : COMPL 07/08/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3300 POPLAR ST  TERRE HAUTE, IN 47803				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	roles; (ii) Provide etraining at least ann documentation of a training; (iv) Demo emergency procedu 483.73(d) (1). This all residents in the findings include:  Based on records reduced birector on 07/08/2 documentation of a Preparedness (EP) to show staff could EP was available for at the time of record birector and the Extraining within the fireview at the time of This finding was reduced.	eview with the Maintenance 4 at 12:30 p.m., no nnual Emergency training and no documentation demonstrate knowledge of the or review. Based on an interview dis review, the Maintenance ecutive Director stated that EP last year was not available for			documentation was on file and be sent with this POC.  The corrective action taken of those residents found to be affected by the deficient practice includes. There are ridentified residents. What: other residents that he the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but no were identified. All newly hire employees receive information Emergency Management Policand Procedures. All current employees receive annual Emergency Management Traivia Relias Training.  The Emergency Training of all employees will continue to be monitored for completion by the Administrator and or HR direct Certificate for each employee be printed upon completion of training. HR will maintain a bit of all completed Training.  Administrator Responsible.  Completion Date: 7.29.24	or  ave y  ne d n on cies  ning	
E 0039 SS=F Bldg	441.184(d)(2), 483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requires \$416.54(d)(2), \$4	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2),					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358			JILDING	NSTRUCTION	(X3) DATE SURVEY  COMPLETED  07/08/2024		
		100000	Б. 11	_		01700	72024
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
MAJESTIC CARE OF DEMING PARK		NG PARK			OPLAR ST HAUTE, IN 47803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.475(d)(2), §4 §483.475(d)(2), §4 (2), §491.12(d)(2)  *[For ASCs at §41 OPO, "Organizatic CMHCs at §485.9 §491.12, and ESF (2) Testing. The [f exercises to test the street of the s	R LSC IDENTIFYING INFORMATION 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) , §494.62(d)(2).  6.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan illity] must do all of the  full-scale exercise that is			CROSS-REFERENCED TO THE APPROPRI	ATE	
	1	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	. ,	ercise or workshop that is					
		and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					

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	AN OF CORRECTION	IDENTIFICATION NUMBER  155358	l í	UILDING	INSTRUCTION	COMPI 07/08	LETED
NAME (	F PROVIDER OR SUPPLIEI			1	ADDRESS, CITY, STATE, ZIP COD		
	STIC CARE OF DEMI				OPLAR ST HAUTE, IN 47803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		pared questions designed					
	to challenge an e	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ergency plan, as needed.					
	(, -, -,	. Э , р					
	*[For Hospices at	418.113(d):]					
	(2) Testing for ho	spices that provide care in					
	the patient's home	e. The hospice must					
		s to test the emergency					
	·	ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
		every 2 years; or					
		nunity based exercise is not					
		ıct an individual facility exercise every 2 years; or					
		experiences a natural or					
	1 ' '	ency that requires activation					
	1	plan, the hospital is					
	1	aging in its next required full					
	· · · · ·	based exercise or individual					
		ctional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct an a	dditional exercise every 2					
	years, opposite th	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
		-scale exercise that is					
		or a facility based					
	functional exercis						
	(B) A mock disas						
		ercise or workshop that is and includes a group					
	discussion using	_ ·					
		emergency scenario, and a					
	1	ements, directed					
		pared questions designed					
	1 0 , 1		1				ì

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING	<del></del>	COMPL	
		155358	B. W	ING		07/08/	/2024
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					OPLAR ST		
MAJEST	IC CARE OF DEMI	NG PARK		TERRE	HAUTE, IN 47803		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	to challenge an er	mergency plan.					
	(2) Tooting for hor	prioce that provide innations					
	1 ' '	spices that provide inpatient hospice must conduct					
	I -	he emergency plan twice					
		spice must do the following:					
	1 ' '	an annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					
	l ` '	ict an annual individual					
		ctional exercise; or					
	1	experiences a natural or					
	` '	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	(ii) Conduct an ad	dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based	or a facility based					
	functional exercise						
	(B) A mock disas						
		ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	•					
	1 -	rio, and a set of problem					
		ted messages, or prepared					
	l '	ed to challenge an					
	emergency plan.						
	1 ' '	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	uie nospice's eme	ergency plan, as needed.					
		141.184(d), Hospitals at					
	§482.15(d), CAHs	at §485.625(d):]					

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	T OF HEALTH AND HU R MEDICARE & MEDIC	FORM APPROVED OMB NO. 0938-039					
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIE		3300	ET ADDRESS, CITY, STATE, ZIP POPLAR ST RE HAUTE, IN 47803	COD		
1017 (01201	The state of the s			TETITOTE, IN 47000	1 L, IIV 47 003		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
1710	†	PRTF, Hospital, CAH] must	Ind			DITTE	
	conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community (A) When a commaccessible, condufacility-based function (B) If the [PRTF, I an actual natural that requires active plan, the [facility] its next required for individual, facilifollowing the onse (ii) Conduct exercise or and the limited to the follo (A) A second full-community-based facility-based function (B) A more (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preto challenge an element of the community of	at to test the emergency ar. The [PRTF, Hospital, ar following: an annual full-scale exercise abased; or aunity-based exercise is not act an annual individual, actional exercise; or allospital, CAH] experiences ar man-made emergency ation of the emergency ation in [additional] annual at may include, but is not at may include, but is not ational exercise that is ar individual, a ational exercise; or actional exercise or workshop that are and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed					
	and maintain doct tabletop exercises and revise the [far needed. *[For PACE at §4]	umentation of all drills, s, and emergency events cility's] emergency plan, as					

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conduct exercises to test the emergency plan at least annually. The PACE

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	N OF CORRECTION	IDENTIFICATION NUMBER  155358	UILDING	nstruction 	COMPI 07/08	LETED
	F PROVIDER OR SUPPLIEF		3300 PC	ADDRESS, CITY, STATE, ZIP COD DPLAR ST HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, condu- facility-based function (B) If the PACE ex- or man-made emeractivation of the exist exempt from en- full-scale community-based functional exercise of the emeractive functional exercise of this section is of the emeractive functional exercise of this section is of the emeractive functional exercise based functional exercise based functional exercises in a functional exercises based functional exercises based functional exercises based functional exercises community-based based functional exercises based functional exercises based functional exercises based functional exercises community-based based functional exercises based functional exercises based functional exercises community-based based functional exercises community-based functional exercises community-based functional exercises based functional exercises community-based functional exercises c	an annual full-scale exercise abased; or aunity-based exercise is not act an annual individual, ational exercise; or experiences an actual natural argency that requires argency plan, the PACE agaging in its next required aity based or individual, ational exercise following the agency event. an additional exercise every an additional exercise every are under paragraph (d)(2)(i) anducted that may include, attended that is a or individual, a facility axercise; or a ter drill; or a tercise or workshop that is and includes a group a narrated, and includes and in				

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER  155358	 UILDING	INSTRUCTION	COMPI 07/08	LETED
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF DEMI	NG PARK		OPLAR ST HAUTE, IN 47803		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION  an annual full-scale exercise	TAG	DEFICIENCY		DATE
	that is community					
		nunity-based exercise is not				
	accessible, condu	ıct an annual individual,				
	facility-based fund	ctional exercise.				
	(B) If the [LTC fac	ility] facility experiences an				
		nan-made emergency that				
		n of the emergency plan, the				
		mpt from engaging its next				
		lle community-based or				
		based functional exercise				
	_	et of the emergency event.				
		dditional annual exercise				
	following:	but is not limited to the				
	_	scale exercise that is				
	1 ' '	or an individual, facility				
	based functional					
	(B) A mock disas					
	1 ' '	ercise or workshop that is				
	led by a facilitator	· · · · · · · · · · · · · · · · · · ·				
	discussion, using					
	_	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er	mergency plan.				
	(iii) Analyze the [I	LTC facility] facility's				
	response to and n	naintain documentation of				
	all drills, tabletop	exercises, and emergency				
		e the [LTC facility] facility's				
	emergency plan, a	as needed.				
	*[For ICF/IIDs at §	§483.475(d)]:				
	-	CF/IID must conduct				
		he emergency plan at least				
		e ICF/IID must do the				
	following:					
	(i) Participate in a	n annual full-scale exercise				
	that is community					
	(A) When a comm	nunity-based exercise is not				

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	OF CORRECTION	IDENTIFICATION NUMBER  155358	 UILDING	nstruction 	COMPI 07/08	LETED
NAME OF I	PROVIDER OR SUPPLIEF	<b>.</b>		ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF DEMI	NG PARK		OPLAR ST HAUTE, IN 47803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENC!)		DATE
	· ·	ct an annual individual, ctional exercise; or.				
		experiences an actual				
	, ,	ade emergency that requires				
		mergency plan, the ICF/IID				
		gaging in its next required				
	-	nity-based or individual,				
		tional exercise following the				
	onset of the emer	gency event.				
	(ii) Conduct an ad	ditional annual exercise				
	that may include,	but is not limited to the				
	following:					
		scale exercise that is				
	community-based					
	facility-based fund					
	(B) A mock disast					
		ercise or workshop that is				
	discussion, using	and includes a group				
	_	emergency scenario, and a				
	set of problem sta					
	-	pared questions designed				
	to challenge an er					
	_	CF/IID's response to and				
	maintain documer	ntation of all drills, tabletop				
	exercises, and em	nergency events, and revise				
	the ICF/IID's emer	rgency plan, as needed.				
	*[For HHAs at §48	34.102]				
		e HHA must conduct				
	exercises to test t	he emergency plan at				
	least annually. Th	e HHA must do the				
	following:					
		full-scale exercise that is				
	community-based					
	, ,	ommunity-based exercise				
		conduct an annual				
	-	based functional exercise				
	every 2 years; or.					
	(B) If the HH	A experiences an actual				1

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIE		·	3300 PC	ADDRESS, CITY, STATE, ZIP COD DPLAR ST HAUTE, IN 47803			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	activation of the exempt from eng full-scale commu facility based fun onset of the eme	nade emergency that requires emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the rgency event.  dditional exercise every 2						
	· '	he year the full-scale or						
		se under paragraph (d)(2)(i)						
	of this section is							
		t limited to the following:						
		d full-scale exercise that is						
	community-base	d or an individual,						
	facility-based fun	ctional exercise; or						
	(B) A mock of	disaster drill; or						
	(C) A tableto	pp exercise or workshop that						
	is led by a facilita	tor and includes a group						
	discussion, using							
	-	t emergency scenario, and a						
	1	atements, directed						
		epared questions designed						
	to challenge an e							
	1 ' '	HHA's response to and						
		entation of all drills, tabletop						
		mergency events, and revise						
	the HHA's emerg	jency plan, as needed.						
	*[For OPOs at §4	=						
	` ' ' '	ne OPO must conduct						
		the emergency plan. The						
	OPO must do the	_						
		per-based, tabletop exercise						
	•	east annually. A tabletop						
	1	/ a facilitator and includes a						
	• .	, using a narrated, clinically						
	_	ncy scenario, and a set of						
		nts, directed messages, or						
	1	ns designed to challenge an						
		If the OPO experiences an man-made emergency that						

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ENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED		
		155358	B. WING		07/08/2024		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK			STREET ADDRESS, CITY, STATE, ZIP COD  3300 POPLAR ST  TERRE HAUTE, IN 47803				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
	OPO is exempt from required testing exempt from the emergency (ii) Analyze the Office maintain document exercises, and empth of the [RNHCl's and needed.]	PO's response to and ntation of all tabletop nergency events, and revise OPO's] emergency plan, as					
	exercises to test ti RNHCI must do ti (i) Conduct a pape at least annually, group discussion in narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain documer exercises, and enter the RNHCI's emel Based on record revisited to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-conduct facility-based funct b. If the LTC facility or man-made emerging the stage of the conduct of the conduct of the conduct facility or man-made emerging the conduct of the conduct	e RNHCI must conduct the emergency plan. The the following: er-based, tabletop exercise A tabletop exercise is a ted by a facilitator, using a trelevant emergency to of problem statements, so, or prepared questions range an emergency plan. NHCI's response to and thatation of all tabletop therefore events, and revise regency plan, as needed. Therefore year, including the distribution of the tabletop there year, including the distribution of the tabletop there is to test the emergency there is to test the emergency there is to test the emergency there is the tabletop	E 0039	p="" xml: paraid="22901326" paraeid="{0076fd85-96e1-4b: 0-d9e2ebd61114}{12}">  The corrective action taken those residents found to be affected by the deficient practice includes there are i identified residents What: other residents that have the potential to be affected by the same defect practice will be identified an what corrective action will be	for no ive		

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from engaging its next required full-scale in a

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taken.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  (X3) DATE SURVEY COMPLETED 07/08/2024			LETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3300 POPLAR ST  TERRE HAUTE, IN 47803				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION or individual facility-based		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  On 10/17/2023 an amorgonous		(X5) COMPLETION DATE
	full-scale functional the onset of the actu (ii) Conduct an addinclude, but is not lia. A second full-scale community-based of functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that inclual a narrated, clinically and a set of problem messages, or preparchallenge an emerge (iii) Analyze the LT maintain documental exercises, and emer LTC facility's emergaccordance with 42 deficient practice confidence of the problem of the problem in the problem of the proble	itional exercise that may imited to the following: ale exercise that is or an individual, facility-based drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to			On 10/17/2023 an emergency Drill Exercise was held at Deming Park and the documentation was in the TELS program. ED was unaware that Director did not look in TELS for the documentation at the time of the Life Safety Survey. The emergency plan will be reviewed at least annually, a this task will be entered into the TELS PM system for monitoring by the Administrator and Maintenar Director and included in the QAPI process for systems reviews.  ED held another Emergency Drill on 7/23/2024 discussing Tornado Preparedness.  Documentation will be sent with this POC.  The facility will continue to conduct Emergency Drills including unannounced drill at least twice a year, and document response.  These drills will be entered into TELS, the Maintenance Director or Administrator will be responsible for monitoring for compliance. Date of Compliance: 7.29.24	t f nd nce	

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		IDENTIFICATION NUMBER  155358	JILDING	NSTRUCTION	COMPL 07/08/	ETED
	PROVIDER OR SUPPLIER		3300 PC	DDRESS, CITY, STATE, ZIP COD DPLAR ST HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION chance Director during the exit	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	§482.15(e) Conditive (e) Emergency and The hospital must standby power systemergency plan set this section and in procedures plan set (i) and (ii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (iii) and (iii) of this section and in procedures plan set (iii) and (iii) of this set (iii) and (iii) of this set (iii) and (iii) of this set (iii) and in procedures systems based on forth in paragraph sys	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. Indicate the CAH] must ency and standby power the emergency plan set (a) of this section.  63.73(e)(1), §485.625(e)(1) eator location. The located in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new when an existing				

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPLETED	
		155358	B. W	ING		07/08	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OPLAR ST		
MAJEST	IC CARE OF DEMI	NG PARK		TERRE	HAUTE, IN 47803		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
		FPA 110, and Life Safety					
	Code.						
	192 15(0)(3) \$49	3.73(e)(3), §485.625(e)(3)					
	. , , , _	rator fuel. [Hospitals, CAHs					
		that maintain an onsite fuel					
		emergency generators must					
	_	ow it will keep emergency					
	1	perational during the					
	emergency, unles						
	] 3 3,						
	*[For hospitals at	§482.15(h), LTC at					
	§483.73(g), and C	CAHs §485.625(g):]					
	The standards inc	corporated by reference in					
	this section are ap	oproved for incorporation by					
	reference by the [	Director of the Office of the					
	Federal Register i	in accordance with 5 U.S.C.					
	` '	R part 51. You may obtain					
	the material from	the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
		ARA, call 202-741-6030, or					
	go to:	<i>(</i> , ) , , , , , , , , , , , , , , , , , ,					
		es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		ederal Register to					
	announce the cha	<del>-</del>					
	Batterymarch Par	Protection Association, 1					
	Quincy, MA 02169						
	1.617.770.3000.	ə, www.nipa.org,					
		th Care Facilities Code,					
	1 ' '	ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued	• • •					

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ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155358	B. WING		07/08/2024	
	PROVIDER OR SUPPLIER		3300 F	ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF DEMI	NG PARK	TERRI	E HAUTE, IN 47803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	(iii) TIA 12-3 to NF	FPA 99, issued August 9,				
	2012.					
	(iv) TIA 12-4 to NI	FPA 99, issued March 7,				
	2013.					
	(v) TIA 12-5 to NF	FPA 99, issued August 1,				
	2013.					
	` '	FPA 99, issued March 3,				
	2014.					
	. ,	ife Safety Code, 2012				
	edition, issued Au	•				
		NFPA 101, issued August				
	11, 2011.					
		FPA 101, issued October				
	30, 2012.	TDA 404 issued Ostaban				
	(X) TIA 12-3 to NF 22, 2013.	FPA 101, issued October				
	1	FPA 101, issued October				
	22, 2013.	FFA 101, Issued October				
	1	Standard for Emergency and				
	` '	ystems, 2010 edition,				
		chapter 7, issued August 6,				
	2009					
		view and interview, the facility	E 0041	It is the policy of this facility to	07/29/2025	
		t the emergency power system		monitor the emergency genera		
	inspection, testing,	and maintenance requirements		on a weekly basis.		
	found in the Health	Care Facilities Code, NFPA		The corrective action taken f	or	
	110, and Life Safet	y Code in accordance with 42		those residents found to be		
	CFR 483.73(e)(2).	This deficient practice could		affected by the deficient		
	affect all occupants	3.		practice. There are no		
				identified residents. practice		
	Findings include:			How other residents that have		
				the potential to be affected b	у	
		eview and interview with the		the same defective practice		
		tor on 07/08/24 between 9:45		will be identified and what		
		, no documentation was		corrective action will be		
		v to show the generator set in		taken: All residents have the		
		sed at least once monthly, for a		potential to be affected but not	ne	
		nutes since February 2024.		were identified.		
	Additionally, mont	hly load testing for the months		What measures will be put		

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of July to December 2023 were not available to

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into place and what systemic

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/08/2024
	ROVIDER OR SUPPLIER		3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST E HAUTE, IN 47803	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	review, the Maintenbeen on the job for additional documentests, and none were time of the survey.  Based on review of Inspection" documentestor during recording recording to the survey of the survey.  Based on review of Inspection documentestor during recording recording to the survey of the sur	terview at the time of record ance Director stated he had three weeks, checked for tation for monthly generator e available for review at the "Emergency Generator - Visual entation with the Maintenance ord review from 9:45 a.m. to 8/24, documentation of weekly or inspections for July through not available for review. enerator weekly visual first three weeks of June 2024 for review. Based on interview of review, the Maintenance and been on the job for three visual inspection on the possible for more weekly and confirmed that the review. The forementioned time frames for review.  The review of the Executive enance Director at the exit		changes will be made to ensure that the deficient practice does not recur: The new Maintenance Director wa informed of the deficient practice the Emergency generator will tested weekly by the Maintena Director and results recorded. How the corrective action who be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place: An audit will be conducted monthly with the quality assurance committed assure that the Emergency Generator is being tested weekly and documentation is completed at the times of testing. Administrator Responsible Compliance Da 7.29.24	is stice. I be ance vill sity out
K 0000					
Bldg. 01	Licensure Survey w		K 0000	By submitting the enclosed materials, we are not admittin truth or accuracy of any specifindings or allegations. We rethe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our	fic serve s or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED	
		155358	B. W	ING		07/08	/2024	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	2			OPLAR ST			
MAJESTI	IC CARE OF DEMII	NG PARK		TERRE HAUTE, IN 47803				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DA		
	Provider Number:				regulatory obligations. The fa	-		
	AIM Number: 100267640				request that the plan of correc			
					be considered our allegation of			
	-	Code survey, Majestic Care of			compliance effective 7/29/24 t			
	-	ound not in compliance with			life safety survey completed o			
	Requirements for P	-			7/8/24. We respectfully reque			
		, 42 CFR Subpart 483.90(a),			paper review and will provide	-		
		ire and the 2012 Edition of the			additional information request	ea.		
		ction Association (NFPA) 101,						
		LSC), Chapter 19, Existing ancies and 410 IAC 16.2.						
	Health Care Occupa	ancies and 410 IAC 10.2.						
	This one story facil	ity with a partial basement was						
		Type II (000) construction and						
		he facility has a fire alarm						
		ired smoke detection in the						
	-	oms, corridors and in all areas						
		The facility has a capacity of						
	-	s of 62 at the time of this visit.						
	oo ana naa a censa.	of 62 at the time of this visit.						
	All areas where resi	idents have customary access						
		Il areas providing facility						
	services were sprinl							
	1							
	Quality Review con	mpleted on 07/10/24						
K 0291	NFPA 101							
SS=D	Emergency Lightin	ng						
Bldg. 01	Emergency Lightin	_						
		ig of at least 1-1/2-hour						
		ed automatically in						
	accordance with 7	7.9.						
	18.2.9.1, 19.2.9.1							
		view, observation and	K 0	291	It is the policy of this facility	to	07/29/2024	
	interview; the facili	ty failed to ensure 3 of 3			monitor the emergency light			
	battery backup light	ts were tested monthly and			on a monthly basis.			
		utes over the past year to			The corrective action taken f	or		
		uld provide lighting during			those residents found to be			
	periods of power or	itages and a written record of			affected by the deficient			
	visual inspections a	nd tests was provided.	1		practice There are no		1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/08/2024	
	ROVIDER OR SUPPLIER		3300 F	ADDRESS, CITY, STATE, ZIP COD POPLAR ST E HAUTE, IN 47803	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Section 7.9.3.1.1 (1) shall be conducted a weeks and a maxim for not less than 30 testing shall be conducted a staff.  Findings include:  Based on record revito 12:50 p.m. with twas no annual Batte Testing available for the time of record revito 12:50 p.m. with twas no annual Batte Testing available for the time of record revito 12:50 p.m. with twas no annual Batte Testing available for the time of record review. Additionally for July through No 2024 was not availar observations during Maintenance Direct to 2:50 p.m., the face mergency light on generator and two be lights were located interview with the Matted no monthly to	prequires functional testing monthly, with a minimum of 3 um of 5 weeks between tests, seconds, (3) Functional flucted annually for a minimum emergency lighting system is a (5) Written records of visual as shall be kept by the owner end authority having efficient practice could affect review. Based on interview at eview, the Maintenance Director, there exists a battery operated the generator and in the boiler tation for annual test within this was not available for y, 30 second monthly testing vember 2023, May and June of ble for review. Based on a tour of the facility with the or on 07/08/24 from 12:50 p.m. willity has a battery operated the exterior wall by the attery operated emergency in the boiler room. Based on Maintenance Director, he esting for the aforementioned unal testing was available for		identified residents. How other residents that ha the potential to be affected the same defective practice will be identified and what corrective action will be taken: All residents have th potential to be affected but none were identified.  What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur: The new Maintenance Director winformed of the deficient practice. The Battery-Opera Emergency Testing will be performed on monthly basis 30 seconds and annually fo minutes. One of the two emergency light cited as a battery-operated light (near generator) is not battery powered. It is direct wired a operates by a light switch. How the corrective action when the corrective action when the conducted monthly to assu that emergency lighting is being tested weekly and documentation is complete.	e DATE  ve by  e vas ated s for r 90  nd vill e lity put re
		e reviewed with the Executive enance Director at the exit		the time of testing.  Documentation of these tes will be reviewed by the qual assurance committee.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155358		CORRECTION IDENTIFICATION NUMBER A. BUILDING OB. WING		01	COMPL	DATE SURVEY COMPLETED 07/08/2024	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 3300 POPLAR ST TERRE HAUTE, IN 47803					
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\TE	(X5) COMPLETION DATE		
	3.1-19(b)				Executive Director Responsible. Completion: 7.29.24				
K 0345 SS=C Bldg. 01	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  3.1-19(b)  K 0345 NFPA 101 SS=C Fire Alarm System - Testing and		K 03	345	The corrective action taken of those residents found to be affected by the deficient practice. There are no identification residents.  What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:  SafeCare came to the facility July 17, 2024 and reset fire all system to display the correct of and time.  How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken: All residents have the potential to be affected but no were identified.	c on darm date ve	07/29/2024		

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155358		ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 07/08/2024
	PROVIDER OR SUPPLIER IC CARE OF DEMING PARK	3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST E HAUTE, IN 47803	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.  3.1-19(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will visu inspect the fire panel daily (Monday-Friday) to ensure accurate date and time.  Administrator to complete rand audits for compliance and recein TEL's PM system.  Administrator Responsible.  Completion: 7.29.24	ally
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility	K 0351	The corrective action taken f	for 07/29/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION  G  01	(X3) DATE SURVEY COMPLETED 07/08/2024
	ROVIDER OR SUPPLIER		330	EET ADDRESS, CITY, STATE, ZIP COD 0 POPLAR ST RRE HAUTE, IN 47803	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION the ceiling construction in	ID PREFII TAG	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION DATE
	Physical Therapy in Standard for the Ins NFPA 13, 2010 edit plates, escutcheons, cover the annular spide metallic, or shall sprinkler. This deficand at least 3 reside Findings include:  Based on observation Director on 07/08/2 the restroom located approximate half in sprinkler that exposinterview at the tim Maintenance Direct space around the spide Physical Therapy results.	tallation of Sprinkler Systems. tion, Section 6.2.7.1 states or other devices used to bace around a sprinkler shall be listed for use around a tient practice could affect staff ints in Physical Therapy.  on with the Maintenance 4 at 1:35 p.m., the sprinkler in d in Physical Therapy had an ech annular space around the ed the attic. Based on e of observation, the or confirmed the half inch rinkler exposed the attic in the		affected by the deficient practice. There are no ic residents.  How other residents that the potential to be affect the same defective practive action will be affected but were not identified by the surveyor what measures will be place and what systemic changes will be made to ensure that the deficient practice does not recur: SafeCare will install escuron the annular space arosprinkler heads.  What measures will be into place and what systemic changes will be made to ensure that the deficient practice does not recur: SafeCare will install escuron the annular space arosprinkler heads.  What measures will be into place and what system changes will be made to ensure that the deficient practice does not recur: Maintenance Director will monthly audits, to ensure annular space around spineads are present.  Administrator Responsible Completion: 7.29.24	dentified  t have ted by tice lat taken: potential ot but into c tthcheons und the  put temic t The conduct that rinkler
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N	Maintenance and Testing Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of			

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/08/2024 155358 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3300 POPLAR ST MAJESTIC CARE OF DEMING PARK TERRE HAUTE, IN 47803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the K 0353 The corrective action taken for 07/31/2024 facility failed to document sprinkler system those residents found to be inspections in accordance with NFPA 25. NFPA affected by the deficient 25, Standard for the Inspection, Testing, and **practice.** There are no identified Maintenance of Water-Based Fire Protection residents. Systems, 2011 Edition, Section 5.2.4.2 states The corrective action taken gauges on dry pipe sprinkler systems shall be for those residents found to be inspected weekly to ensure that normal air and affected by the deficient water pressures are being maintained. Section practice. All residents have the 5.1.2 states valves and fire department potential to be affected. connections shall be inspected, tested, and What measures will be put into maintained in accordance with Chapter 13. Section place and what systemic 13.1.1.2 states Table 13.1.1.2 shall be utilized for changes will be made to inspection, testing and maintenance of valves, ensure that the deficient valve components and trim. Section 4.3.1 states practice does not recur: New records shall be made for all inspections, tests, Maintenance Director updated on and maintenance of the system and its the status of dry sprinkler testing. components and shall be made available to the Dry sprinkler testing has been authority having jurisdiction upon request. This completed. deficient practice could affect all residents, staff, What measures will be put and visitors. into place and what systemic changes will be made to Findings include: ensure that the deficient

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Based on review of documentation for the most

recent twelve month period with the Maintenance

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practice does not recur: The

to do weekly Dry Sprinkler

Maintenance Director will continue

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  07/08/2024	
	PROVIDER OR SUPPLIER		3300 F	ADDRESS, CITY, STATE, ZIP COPLAR ST E HAUTE, IN 47803	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RS PLAN OF CORRECTION CTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)  CX5)  COMPLETION DATE	
	Director during rec 12:50 p.m. on 07/03 system gauge inspet through October 20 review. Additionall inspections for Apravailable for review inspection documer control valves for 7 month period was ron interview at the Maintenance Direct job three weeks and gauge and control valves for 9 documentation for periods was not ava. This finding was re Director and Maint conference.  2. Based on observate facility failed to ensure the walkin freezer value are placed in accordance Standard for the Insumaintenance of Wasystems, 2011 Edit sprinklers shall not be free of corrosion physical damage; a correct orientation of sidewall). Furthern that shows signs of replaced:  (1) Leakage (2) Corrosion (3) Physical Damage	ord review from 9:45 a.m. to 8/24, weekly dry sprinkler ction documentation for July 23 was not available for y, dry sprinkler gauge il through June 2024 were not v. In addition, monthly nation for all sprinkler system months of the most recent 12 not available for review. Based time of record review, the tor stated he has been on the disconfirmed sprinkler system railve inspection the aforementioned weekly nilable for review.  Viewed with the Executive enance Director at the exit ation, and interview; the sure 1 of 1 sprinkler heads in with a bent deflector was not with NFPA 25. NFPA 25, spection, Testing, and ter-Based Fire Protection ion, Section 5.2.1.1.1 states show signs of leakage; shall the foreign materials, paint, and and shall be installed in the feeg., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler any of the following shall be		Inspections of the sprin system and document ED will conduct random ensure compliance. The entered into the TEI system.  Safe Care replaced the sprinkler deflector Tile in the linen closet of been replaced.  Administrator Respons Completion: 7.31.24	kler putcomes. n audits to is task will s PM bent ceiling has	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/08/2024	
		199996	b. wind		07/06/2024	
NAME OF P	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF DEMI	NG PARK		OPLAR ST HAUTE, IN 47803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	(5) Loading	mainted by the amindran				
		painted by the sprinkler				
		enrinklers that are loaded with				
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (5) Loading  (6) Painting unless painted by the sprinkler manufacturer.  In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.  This deficient practice could affect dietary staff.  Findings include:  Based on observation with the Maintenance Director during a tour of the facility at 2:47 p.m. on 07/08/24, the sprinkler located in the walk in freezer had a bent and damaged deflector. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler had a bent deflector.  This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.  3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 200 Hall Linen rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant						
	NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (5) Loading (6) Painting unless painted by the sprinkler manufacturer.  In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.  This deficient practice could affect dietary staff.  Findings include:  Based on observation with the Maintenance Director during a tour of the facility at 2:47 p.m. on 07/08/24, the sprinkler located in the walk in freezer had a bent and damaged deflector. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler had a bent deflector.  This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.  3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 200 Hall Linen rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a					
		-				
		see could unless alounly sum.				
	Director during a to 07/08/24, the sprinl freezer had a bent a on interview at the Maintenance Direct bent deflector.  This finding was re Director and Maintenance Directo	our of the facility at 2:47 p.m. on kler located in the walk in and damaged deflector. Based time of observation, the tor agreed the sprinkler had a eviewed with the Executive				
	3. Based on observation failed to maintain the 200 Hall Linen root Section 3.3.5.4 deficient in the continuous ceiling in irregularities, lump traps hot air and gacauses the sprinkler temperature. Section between the sprinkler above shall be selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and the type deficient practice contains the selected sprinkler and	the ceiling construction in 1 of 1 ms. NFPA 13, 2010 edition, sines a smooth ceiling as a free from significant s, or indentations. The ceiling ses around the sprinkler and r to operate at a specified on 8.5.4.1.1 states the distance				

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

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	OF CORRECTION	IDENTIFICATION NUMBER  155358	A. BUILDING B. WING	01	COMPLETED 07/08/2024
	ROVIDER OR SUPPLIER		3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST E HAUTE, IN 47803	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	Director during a too 07/08/24, a two foot tiles were missing in resident room 215. The exposed the attic space equipped with one put the ceiling. Based on observation, the Mathemissing ceiling to the missing ceiling and missing ceiling the missing cei	t quarterly on each shift.  r with procedures and is the part of established tills are conducted between AM, a coded by be used instead of	K 0712	It is the policy of this facility conduct quarterly fire drills ceach shift on unexpected da and at unexpected times und varying conditions.  How other residents that have the potential to be affected by	on ys der re

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	ILTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLETED
		155358	B. WI	NG		07/08/2024
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	
		-			OPLAR ST	
MAJEST	IC CARE OF DEMI	NG PARK		TERRE	HAUTE, IN 47803	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		This deficient practice affects			the same defective practice	
	all staff and residen	its.			will be identified and what	
	Findings include:				corrective action will be taken. All residents have the	
	rindings include.				potential to be affected but	
	Based on records review with the Maintenance				none were identified. A fire	
Director on 07/08/24 at 10:20 a.m., the following					drill was conducted on	
was noted:				7/15/2024.		
a) no fire drill documentation was available for the				What measures will be put in	nto	
<ul><li>a) no fire drill documentation was available for the first and second shifts for the first quarter of 2024</li><li>b) no fire drill documentation was available for the</li></ul>		-			place and what systemic	
	· /				changes will be made to	
		ft for the second quarter of			ensure that the deficient	
	2024				practice does not recur: The	
	· /	n was available to show a first			new Maintenance director w	
		lrill for the third quarter of			in-service that fire drills mus	st
	2023/2024				be held every month on	
	· ·	n was available to show a first edrill for the fourth quarter of			staggering dates and times	
	2023	e drin for the fourth quarter of			throughout the month. Every quarter a drill must be	′
		ew at the time of record review,			conducted on each shift. Dri	lle
		rector stated he had been on			that occur on the night shift	
		eks, had searched for fire drill			with a silent alarm must be	
	-	additional documentation was			reviewed and alarm soundin	g
	available for review	7.			the following day.	
					Transmission of a fire alarm	
	_	viewed with the Executive			signal and simulation of the	
		aintenance Director during the			emergency fire conditions m	<b>I</b>
	exit conference.				occur and will be documented	ed
	2 Dag-1 1	marriage and intermitate 41			on the fire drill paperwork.	
		review and interview, the sure 1 of 12 fire drills included			How the corrective action w	III
		ransmission of the fire alarm			be monitored to	
					ensure the deficient practice will not recur, i.e., what qual	
	signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the				assurance program will be p	=
					into place: The Maintenance	<b>I</b>
					director and/or his designee	
	_	re alarm signal and simulation			will conduct monthly fire dri	
		onditions. This deficient			that are on different shifts ar	
		residents in the facility as well			staggered throughout the	
	as staff and visitors				month, quarter and year. Thi	۹ ا

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155358	B. W	ING		07/08/	2024
	ROVIDER OR SUPPLIER			3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST HAUTE, IN 47803		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	with the Maintenand 10:15 a.m., the fire of 11:30 p.m., had no is area to indicate transinterview at the time Maintenance Direct job three weeks and 11:30 p.m. fire drill verification of the transition of the t	riew of titled "Fire Drill Report" ce Director on 07/08/24 at drill documented 02/09/24 at information documented in the smission of signal. Based on e of record review, the or stated he had been on the confirmed the 02/09/24 at did not document the ransmission of alarm.  Eviewed with the Executive enance Director at the exit			task will be entered into the TELS PM system. The times will also be staggered throug a 24-hour period, so they all don't fall at the time on the same shift. Fire drill paperwowill be completed. Documentation of the transmission of the signal ar outcome of simulation will be completed. Drills will be brought to the quarterly QA meetings for review and sign by attendees. Administrator responsible. Completion: 7.29.24	ork nd e	
K 0761 SS=D Bldg. 01	failed to ensure anniat least 1 fire door a accordance of LSC openings in dividing 19.1.1.4.1 shall be protected by door assemblies. (So 8.3.3.1 Openings rerating by Table 8.3. approved, listed, lab fire window assembliardware, including anchorage, and sills	view and interview, the facility ual inspection and testing of ssemblies were completed in 19.1.1.4.1.1 communicating g fire barriers required by permitted only in corridors and y approved self-closing fire ee also Section 8.3.) LSC quired to have a fire protection 4.2 shall be protected by peled fire door assemblies and their accompanying g all frames, closing devices, in accordance with the	K 0	761	It is the policy of this facility ensure fire doors are inspect annually, which has been completed with no documented findings or concerns.  The corrective action taken f those residents found to be affected by the deficient practice includes There are r identified residents: How other residents that have	ed or no	07/29/2024
	_	PA 80, Standard for Fire Doors Protectives, except as			the potential to be affected b the same defective practice	у	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155358	B. W	ING		07/08/2024
		<u>.</u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEI	₹			OPLAR ST	
MAJEST	IC CARE OF DEMI	NG PARK		TERRE	HAUTE, IN 47803	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID		(X5)
				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
	`			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
					will be identified and what	
	•				corrective action will be take	en:
					All residents have the potent	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of				to be affected but none were		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label.				identified.		
				What measures will be put in	nto	
					place and what systemic	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  (X4) ID  PREFIX  TAG  SUMMARY STATEMENT OF DEFICIENCIE  REGULATORY OR LSC IDENTIFYING INFORMATION  otherwise specified in this Code. NFPA 80 5.2.1  states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:  (1) No open holes or breaks exist in surfaces of either the door or frame.  (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.  (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.  (4) No parts are missing or broken.  (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.  (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.  (7) If a coordinator is installed, the inactive leaf closes before the active leaf.  (8) Latching hardware operates and secures the door when it is in the closed position.  (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.  (10) No field modifications to the door assembly				changes will be made to		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  otherwise specified in this Code. NFPA 80 5.2.1  states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:  (1) No open holes or breaks exist in surfaces of either the door or frame.  (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.  (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.  (4) No parts are missing or broken.  (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.  (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.  (7) If a coordinator is installed, the inactive leaf closes before the active leaf.  (8) Latching hardware operates and secures the door when it is in the closed position.  (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.  (10) No field modifications to the door assembly have been performed that void the label.  (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.				ensure that the deficient		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  otherwise specified in this Code. NFPA 80 5.2.1  states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:  (1) No open holes or breaks exist in surfaces of either the door or frame.  (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.  (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.  (4) No parts are missing or broken.  (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.  (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.  (7) If a coordinator is installed, the inactive leaf closes before the active leaf.  (8) Latching hardware operates and secures the door when it is in the closed position.  (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.  (10) No field modifications to the door assembly have been performed that void the label.  (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect staff.				practice does not recur: All t	fire	
					doors have been inspected a	
<ul><li>(1) No open holes or breaks exist in surfaces of either the door or frame.</li><li>(2) Glazing, vision light frames, and glazing beads</li></ul>				findings documented. All do	I	
	· · ·				will be inspected at lease	
					annually and findings	
	(3) The door, frame	e, hinges, hardware, and			documented. This task will b	oe l
	, ,	_			entered into the TELS PM	
	and in working ord	er with no visible signs of			system.	
	damage.				How the corrective action wi	11
	(4) No parts are mi	ssing or broken.			be monitored to	
	(5) Door clearances	s do not exceed clearances			ensure the deficient practice	,
	listed in 4.8.4 and 6	5.3.1.7.			will not recur, i.e., what qual	ity
	(6) The self-closing	g device is operational; that is,			assurance program will be p	ut
	the active door con	pletely closes when operated			into place: The Maintenace	
					Director will put the complet	ed
					Fire Door Inspection into TE	LS.
					Administrator will review wh	en
		-			completed. 7.29.24	
		are not installed on the door or				
		<del>-</del>				
	_					
	This deficient pract	ace could affect staff.				
	Findings include:					
	Based on records re	eview with the Maintenance				

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	l í	UILDING	nstruction 01	(X3) DATE COMPI 07/08	LETED
	PROVIDER OR SUPPLIER			3300 PC	DDRESS, CITY, STATE, ZIP COE DPLAR ST HAUTE, IN 47803	·	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Oxygen Transfilling available for review Maintenance Direct all the barrier doors building and marke in the computer bas Maintenance Direct itemized listing of ravailable for review This finding was re	n annual inspection for the groom fire door assembly was 7. Based on interview with the or, he stated that he checked and oxygen room door in the d the task complete on 07/03/24 ed records program. The or stated that an annual equired fire doors was not					
K 0914 SS=E Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not ling these locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visual LIM circuits with a manual test is per than or equal to 15	s - Maintenance and ceptacles at patient bed cre deep sedation or general cinistered, are tested after replacement or servicing. cis performed at intervals cented performance data. cented as hospital-grade at cented at intervals not cented at intervals of cented at intervals less companies comp					

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Event ID:

SSV321 Facility ID: 000249

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155358	B. W	ING		07/08/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OPLAR ST		
MAJEST	IC CARE OF DEMI	NG PARK			E HAUTE, IN 47803		
1017 10 E O 1		110171111		ILIXIXE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	oom or area tested, and					
6.3.4 (NFPA 99)							
		on record review and	K 0	014	What corrective action will b	_	09/01/2024
			I K U	914	accomplished for those	е	08/01/2024
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.				residents found to have been	2		
				affected by the deficient			
	PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.  6.3.4 (NFPA 99)  Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.  Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice				practice: No residents were		
					found to be affected.		
		-			How other residents that have	/e	
	_	-			the potential to be affected b	у	
	general anesthesia i	s administered, shall be tested			the same defective practice	_	
	at intervals not exce	eeding 12 months.			will be identified and what		
	Additionally, Section	on 6.3.3.2, Receptacle Testing			corrective action will be		
					taken. All residents have the		
		-			potential to be affected but		
	_				none were identified.		
		-			What measures will be put in	nto	
					place and what systemic		
		•			changes will be made to		
					ensure that the deficient		
					practice does not recur: The		
					Maintenace Director will test all non-hospital grade		
					receptacles on an annual ba	sis	
	I Sala alleet lesiden	on 200 Hum			and document results. All	0.0	
	Findings include:				non-hospital grade outlets h	ave	
					been tested and results	-	
	Based on record rev	view with the Maintenance			documented.		
	Director at 12:20 p.	m. on 07/08/24, annual					
	receptacle retention	documentation was not			Administrator will audit to		
		v. Based on an interview at the			ensure continued compliance	e.	
		ew, the Maintenance Director			This task will be entered into	)	
		on the job three weeks and			the TELS PM system.		
		complete the testing and that			Compliance 8.1.24		
		tation was not available to					
	review. The Mainte	enance Director stated that					

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155358			A. BUILDING <u>01</u> COMPL B. WING <u>07/08/</u>				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD OPLAR ST		
MAJEST	IC CARE OF DEMIN	NG PARK			HAUTE, IN 47803		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	receptacles and that hospital grade recept observations made of from 12:50 p.m. to 2 rooms had approxim mixture of hospital gwhich would require on interview at the the Maintenance Director rooms on 200 Hall Helectrical receptacle them tested and doc.  This finding was reviously become a conference.  3.1-19(b)  NFPA 101  Electrical Systems Electrical Systems Electrical Systems System Maintenar The generator or source and associof supplying service 10-second criterion monthly test, a programmually confirm the safety and critical and testing of the gwitches are perfoniced under longer in 20-40 day once every 36 more services and services are every 36 more every 36 mor	during a tour of the facility 2:50 p.m., the 200 Hall resident nately six receptacles with a grade and non hospital grade, e an annual inspection. Based ime of observations, the or confirmed that resident nad non hospital grade s and he would have to get umented on an itemized form.  Viewed with the Executive mance Director at the exit  - Essential Electric nce and Testing other alternate power ated equipment is capable we within 10 seconds. If the n is not met during the ncess shall be provided to nis capability for the life branches. Maintenance generator and transfer rmed in accordance with  e inspected weekly, and 30 minutes 12 times a intervals, and exercised on the for 4 continuous hours. der load conditions include					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/08/2024			
		ROVIDER OR SUPPLIER			3300 PG	ADDRESS, CITY, STATE, ZIP COD OPLAR ST HAUTE, IN 47803		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TE	(X5) COMPLETION DATE	
		automatic or manuloads, and are corpersonnel. Mainte energy power sour accordance with Noticuit breakers are program for period components is estimated and circuits are manufacturer requires and readily available and circuits are mand separate from Minimizing the posterior power consideration for maintenance of accordance with NFPA 111, 700.101. Based on record facility failed to man of monthly generated 12 months. Chapter requires monthly te the emergency elect accordance with NFE mergency and States. NFPA 110 8.4.2. generator sets shall month with the available or until the water te have stabalized. Chapter requires a written requires a written regenerator to be regular for inspection by the	ual transfer of all EES inducted by competent inance and testing of stored inces (Type 3 EES) are in independent and feeder ite inspected annually, and a dically exercising the itablished according to direments. Written records indicated testing are maintained ble. EES electrical panels indicated panels indicated are maintained ble. EES electrical panels indicated panels indicated are maintained ble. EES electrical panels indicated panels indic	K 0	918	It is the policy of this facility to have a written record of month generator load testing.  The corrective action taken f those residents found to be affected by the deficient practice includes: There are identified residents.  How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but not were identified.  What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The new maintenance director will	or no ve y	07/29/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPL	ETED
		155358	B. WIN	NG		07/08/	/2024
			<del></del>	CTDEET A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGTI		NO DADIC			OPLAR ST		
MAJESTI	IC CARE OF DEMII	NG PARK		IERRE	HAUTE, IN 47803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on records re	eview and interview with the			complete weekly and monthly		
	Maintenance Direct	tor on 07/08/24 between 9:45			testing on the generator. Test	ing	
	a.m. and 12:50 p.m.	., no documentation was			was completed on 7/15/2024 a	and	
	available for review	to show the generator set in			will be completed weekly going		
	service was exercised at least once monthly, for a				forward.		
	minimum of 30 minutes since February 2024.				How the corrective action will	be	
	Additionally, monthly load testing for the months				monitored to		
	of July to December 2023 were not available to				ensure the deficient practice w	/ill	
	review. Based on interview at the time of record				not recur, i.e., what quality		
	review, the Mainter	nance Director stated he had			assurance program will be put	into	
	been on the job for	three weeks, had checked for			place:		
	additional documen	tation for monthly generator			An audit will be conducted		
	tests, and none were	e available for review at the			monthly by the Maintenance		
	time of the survey.				Director and reviewed by the		
					quality assurance committee t	0	
	This finding was re	viewed with the Executive			assure that the Emergency		
	Director and Mainte	enance Director at the exit			Generator is being tested wee	kly	
	conference.				and monthly and documentation	-	
					completed at the time of testin		
	2. Based on record	review and interview, the			Documentation of these tests	-	
	facility failed to ens	sure a written record of weekly			be reviewed by the quality		
	inspections for the	emergency generator set was			assurance committee. Executi	ve	
	maintained for all 5	2 weeks from July 2023 through			Director Responsible. Comple	tion:	
	July 2024. This defi	icient practice could affect all			7.29.24		
	residents, staff and	visitors.					
	Findings include:						
	Based on review of	"Emergency Generator - Visual					
	Inspection" docume	entation with the Maintenance					
	Director during reco	ord review from 9:45 a.m. to					
	12:50 p.m. on 07/08	8/24, documentation of weekly					
	emergency generate	or inspections for July through					
	October 2023 were not available for review.						
	Additionally, the generator weekly visual						
	inspections for the f	first three weeks of June 2024					
	were not available for review. Based on interview						
	at the time of record review, the Maintenance						
		ad been on the job for three					
		visual inspection on					
	i		1		1		1

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	ľ í				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL		
		155358	B. Wl	NG		07/08/	2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
MA IECTI		NC DADK			OPLAR ST			
IVIAJESTI	C CARE OF DEMIN	NG PARK		IERRE	HAUTE, IN 47803			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC! )		DATE	
		cked for more weekly as and confirmed that						
		eekly emergency generator						
		of orementioned time frames						
	were not available f							
	were not available i	or review.						
	This finding was rev	viewed with the Executive						
	Director and Mainte	enance Director at the exit						
	conference.							
	3.1-19(b)							
K 0920	NFPA 101							
SS=E		ent - Power Cords and						
Bldg. 01	Extens							
· ·		ent - Power Cords and						
	Extension Cords							
		patient care vicinity are only						
	used for compone							
		d electrical equipment						
	(PCREE) assembl							
		lified personnel and meet						
		0.2.3.6. Power strips in						
	-	cinity may not be used for						
	, •	personal electronics),						
		n care resident rooms that						
		E. Power strips for PCREE						
		UL 60601-1. Power strips						
		the patient care rooms ) meet UL 1363. In						
		ooms, power strips meet						
		s. All power strips are						
		precautions. Extension						
	-	d as a substitute for fixed						
		re. Extension cords used						
	_	moved immediately upon						
		purpose for which it was						
		s the conditions of 10.2.4.						
		9), 10.2.4 (NFPA 99), 400-8						
	•	(D) (NFPA 70), TIA 12-5						

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155358		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey .eted /2024	
	PROVIDER OR SUPPLIEI			3300 P	ADDRESS, CITY, STATE, ZIP COD OPLAR ST E HAUTE, IN 47803		
MAJEST (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF The Property of The Prop	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION on and interview, the facility of 1 Housekeeping office and flexible cords were not used as d wiring. LSC 9.1.2 requires d equipment shall be in FPA 70, National Electrical ol 11 Edition, Article 400.8 s specifically permitted, flexible all not be used as a substitute a structure. This deficient if and at least 15 residents in compartment.  on with the Maintenance our of the facility on 07/08/24 2:50 p.m. the following was reger was plugged into and extention cord in the se d was plugged into a undry room plug adapter was plugged into n outlet nearest the window in  at the time of each aintenance Director confirmed ords were in use and removed observation. The Maintenance would remove the multiplug titet as soon as he could.	K 0	TERRE ID PREFIX TAG		ents y the s he nts ed ed rds, ed in all that y plug d staff ords as.	(X5) COMPLETION DATE  07/29/2024
	Director and Maint conference  3.1-19(b)	enance Director at the exit					

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Event ID:

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358	r í	UILDING	nstruction 01	COMP	E SURVEY PLETED 8/2024
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF DEMING PARK			STREET ADDRESS, CITY, STATE, ZIP COD  3300 POPLAR ST TERRE HAUTE, IN 47803				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG				TAG	DEFICIENCY)		DATE
K 0923	NFPA 101						
SS=D Bldg. 01	Gas Equipment - Cylinder and Container Storag						
	Gas Equipment - Cylinder and Container Storage						
	Greater than or equal to 3,000 cubic feet						
	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						
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN	` ,					
		d so cylinders are used in					
		ey are received from the					
		cylinders are segregated					
		. When facility employs					
		egral pressure gauge, a					
	_ ·	e considered empty is					
		oty cylinders are marked to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/08/2024 155358 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3300 POPLAR ST TERRE HAUTE, IN 47803 MAJESTIC CARE OF DEMING PARK (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Based on observation and interview, the facility K 0923 What corrective action will be 07/29/2024 failed to ensure a minimum distance of at least five accomplished for those residents feet separated combustible materials from oxygen found to have been affected by the storage equipment in 1 of 1 oxygen storage areas. practice: No residents were NFPA 99, Section 11.3.2.3 requires oxidizing gases identified to be affected. such as oxygen shall be separated from How other residents having the combustibles by one of the following: (1) a potential to be affected by the minimum distance of 20 feet. (2) a minimum same practice will be identified distance of 5 feet if the required storage location and what corrective action should is protected by an automatic sprinkler system in be taken: All residents have the potential to be affected. accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed No combustible items will be cabinet of noncombustible construction having a stored within five feet of oxygen minimum fire protection rating of ½ hour. This cylinders or other deficient practice could affect staff in the vicinity gases. Combustible items have of the oxygen storage room in the garage. been removed and Central Supply staff informed that as soon as Findings include: oxygen supplies are delivered, they should be taken to Central Based on observation on 07/08/24 during the tour Supply room and not stored with of the facility with the Maintenance Director at Oxygen. 1:45 p.m., there were five cardboard boxes filled This will be monitored during with respitory therapy supplies was stored within routine rounds by Maintenance five feet of stationary E type oxygen cylinders in Director and recorded on the log the oxygen storage room. Based on interview at posted in the oxygen room. the time of observation, the Maintenance Director Administrator Responsible. confirmed that combustible materials were staked Completion: 7.29.24 up and stored behind the door of the oxygen room within five feet of stationary oxygen cylinders. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)

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