STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING -- B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/07/22 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Emergency Preparedness survey, Majestic Care of South Bend was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 103 certified beds. At the time of the survey, the census was 61. Quality Review completed on 09/12/22	E 0000		
E 0004 SS=C 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			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING -- B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated	E 0004	**E 004** **Development of Emergency Preparedness Plan**	09/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 09/07/22 from 9:15 a.m. to 9:40 a.m., documentation of an emergency preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past 12 months with the last documented date of review being listed as 07/28/21. Based on interview at the time of record review, the Administrator said that he had not had time to review the Emergency Preparedness plan as of this time. During the exit conference with the facility Administrator, the Regional Director of Plant Operations, and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Facility Emergency Preparedness (EP) plan was developed, updated and maintained. b. Education of all staff on the communication and Implementation of the EP plan. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility updates and development of EP plan. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update EP plan weekly x4, monthly x6, and annually thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e., what quality assurance program will be put into place; a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update the EP plan weekly x4, monthly x6, and annually thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency			

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	preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. These policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan on 09/07/22 from 9:15 a.m. to 9:40 a.m., documentation of emergency preparedness policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past 12 months with the last documented date of review being listed as 07/28/21. Based on interview at the time of record review, the Administrator said that he had not had time to review the Emergency Preparedness plan as of this time. During the exit conference with the	E 0013	**E 013** **Development of Emergency Preparedness Policies and Procedures** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Facility Emergency Preparedness (EP) policies and procedures were developed, updated and maintained. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility updates and	09/24/2022

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	facility Administrator, the Regional Director of Plant Operations, and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding.		development of EP policies and procedures. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update EP policies and procedures weekly x4, monthly x6, and annually thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. The Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update the EP policies and procedures weekly x4, monthly x6, and annually thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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			5. By what date the systemic changes for each deficiency will be completed. a. 9/24/2022.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 09/07/22 from 9:15 a.m. to 9:40 a.m., documentation of emergency preparedness communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed	E 0029	**E 029** **Development of Emergency Preparedness Communication Plan** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Facility emergency Preparedness (EP) plan was developed, updated and maintained. a. Education of all staff on the communication and Implementation of the EP plan.	09/24/2022

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	within the past 12 months with the last documented date of review being listed as 07/28/21. Based on interview at the time of record review, the Administrator said that he had not had time to review the Emergency Preparedness plan as of this time. During the exit conference with the facility Administrator, the Regional Director of Plant Operations, and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility updates and development of EP communication plan. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director, under the supervision of the Executive Director, will review and update EP communication plan weekly x4, monthly x6, and annually thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update the EP communication plan weekly x4, monthly x6, and annually thereafter. b. Plant Operations	

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			Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this			

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	section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 09/07/22 from 9:15 a.m. to 9:40 a.m., documentation of emergency preparedness training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past 12 months with the last documented date of review being listed as 07/28/21. Based on interview at the time of record review, the Administrator said that he had not had time to review the Emergency Preparedness plan as of this time. During the exit conference with the facility Administrator, the Regional Director of Plant Operations, and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0036	**E 036** **Training and Testing** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Facility emergency Preparedness (EP) training and testing program was developed, maintained, and completed to ensure appropriate emergency response of all staff. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility development and maintenance of EP training and testing program. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of	09/24/2022

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			the Executive Director, will review and update EP training and testing program weekly x4, monthly x6 and annually thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update the EP training and testing weekly x4, monthly x6, and annually thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING -- B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]			

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	(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per			

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	year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual			

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	individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or			

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	prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 09/07/22 from 9:15 a.m. to	E 0039	**E 039** **Emergency Preparedness Testing Requirements** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. The facility in collaboration with the fire department conducted EP plan testing exercises to ensure proper responses from all staff.	09/24/2022

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	9:40 a.m., no documentation of: a community or facility-based exercise, a tabletop exercise, or an actual emergency event could be provided. Based on interview at the time of record review, the Administrator stated that as of the time of this survey, he had not yet had time to conduct and document any type of exercises for his staff on emergency preparedness. During the exit conference with the facility Administrator, the Regional Director of Plant Operations, and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding.		a. All staff education and participation of functional exercises that are facility-based/ community-based was completed b. All staff education and participation of mock disaster drills and tabletop exercises were completed. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility EP testing exercises to ensure proper response. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. The Maintenance Director, under the supervision of the Executive Director, will conduct EP plan testing exercises (facility-based/ community-based) weekly x4, monthly x6, and annually thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

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			a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will review and update the EP testing exercises weekly x4, monthly x6, and annually thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/07/22 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Life Safety Code survey, Majestic Care of South Bend was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),	K 0000		

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	Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The building is partially protected by a 150-kW diesel powered emergency generator. The facility has a capacity of 103 beds dually certified for Medicare and Medicaid and had a census of 61 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was fully sprinklered and two wooden storage sheds which were not sprinklered. Quality Review completed on 09/12/22			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas such as a soiled linen rooms was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 14 residents, 4 staff, and 2 visitors. Findings include: Based on observation made with the facility Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance Director during a tour of the facility on 09/07/22 at 12:32 p.m., the corridor door to the North Hall nurse's station Biohazard room was equipped with a self-closing device, but the door failed to fully close and latch into the door frame when tested three separate times. Based on interview at the	K 0321	**K 321** **Enclosures of Hazardous Areas** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, audited and repaired all hazardous area doors to ensure safe separation from other facility spaces. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	09/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned hazardous area failed to fully self-close and latch into the door frame. During the exit conference with the facility Administrator, the R.D.P.O., and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		a. All residents have the potential to be affected by the deficient practice. Full facility audits and repairs of all hazardous area doors. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operation Director/ Designee, under the supervision of the Executive Director, will audit and service all hazardous area doors weekly x4, monthly x6, and annually thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations/ Designee, under the supervision of the Executive Director, will audit and service all hazardous area doors weekly x4, monthly x6 and annually thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			5. By what date the systemic changes for each deficiency will be completed. a. 9/24/2022	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on observation made with the facility Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance Director during a tour of the facility at on 09/07/22 at 12:32 p.m., the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be Sept 3rd at 17:26 Hrs. when the actual date was 09/07/22 and the time was 12:32	K 0345	**K 345** **Fire Alarm System – Testing and Maintenance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, tested, updated, and maintained all fire alarm system in the facility in accordance with the approved program requirements under the NFPA 70, National Electric code, NFPA 72, and National Fire Alarm and Signaling Code. **2. How other residents**	09/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	p.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel as soon as he could. During the exit conference with the facility Administrator, the R.D.P.O., and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility tests and updates of all fire alarm systems to ensure the approved programing. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will test, update, and maintain all fire alarm systems in the facility weekly x4, monthly x6, and quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will test, update, and maintain all fire alarm systems in the facility weekly x4, monthly x6, and quarterly thereafter.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	
K 0351 SS=E 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	**K 351**	09/24/2022

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	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	failed to maintain the ceiling construction in 1 of 1 North Hall electrical closet #1 in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect 14 residents, 4 staff, and 2 visitors. Findings include: Based on observation made with the facility Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance Director during a tour of the facility at on 09/07/22 at 1:01 p.m., the North Hall electrical closet #1 had a one-inch gap between the escutcheon and the ceiling tile therein. Based on interview at the time of observation, the Maintenance Director indicated he was unaware that the escutcheon had fallen away from the ceiling and added that he would have the gap taken care of as soon as he had time to address the issue. During the exit conference with the facility Administrator, the R.D.P.O., and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**Sprinkler System Installation** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, inspected, updated, and maintained all sprinkler system in the facility in accordance with the requirements under the NFPA 13, 2010 Edition. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility inspections and updates of all sprinkler systems to ensure that all code requirements are met. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, test, and maintain all sprinkler systems in the facility weekly x4, monthly x6, and quarterly thereafter.	

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	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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			4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; a. The Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, test, and maintain all sprinkler systems in the facility weekly x4, monthly x6, and quarterly thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have			

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	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 24 residents, 6 staff, and 2 visitors. Findings include: Based on observation made with the facility Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance Director during a tour of the facility at on 09/07/22 at 1:46 p.m., the set of smoke barrier doors nearest to Resident room #122 could not close completely due to a reclining chair being stored between the doors. Based on interview at the time of observations, the Maintenance Director acknowledged these smoke barrier doors could not close completely because the chair obstructed them and immediately removed the chair to a proper storage location removing the issue. This deficiency was removed prior to my exiting of the facility but was still discussed at the exit conference with the facility Administrator, the R.D.P.O., and the Maintenance Director at 2:45 p.m.	K 0374	**K 374** **Subdivision of Building Spaces – Smoke Barriers** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, inspected, repaired, and maintained all smoke barriers in the facility in accordance with the NFPA 101 and Life Safety Code **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility inspections and repairs of all smoke barriers to ensure that all code requirements are met. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient**	09/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	3.1-19(b)		**practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, repair, and maintain all smoke barrier doors in the facility weekly x4, monthly x6, and quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, repair, and maintain all smoke barrier doors in the facility weekly x4, monthly x6, and quarterly thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	

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	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 5 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments	K 0511	**K 511** **Utilities – Gas and Electric** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, inspected and maintained all electrical wiring in the facility in accordance with NFPA 70 and National Electrical Code. a. Full facility inspection and maintenance of all electric outlets within 6ft of wet locations to have ground fault circuit interrupter protection against electric shock. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility inspection and maintenance of all electric	09/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff while at the hand washing sink in the North nurse's station Med room. Findings include: Based on observation made with the facility		outlets within 6ft of wet locations to have ground fault circuit interrupter protection against electric shock. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, repair, and maintain all electric wirings and outlets in the facility to meet the NFPA 70 and National Electric Code requirements weekly x4, monthly x6 and quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, repair, and maintain all electric wirings and outlets in the facility to meet the NFPA 70 and National Electric Code requirements weekly x4, monthly x6 and quarterly thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance Director during a tour of the facility at on 09/07/22 at 1:46 p.m., the North nurses station Med room had a hand-washing sink located within. The light switch for this room was approximately 43 inches from the water source. Based on an interview, when asked if the switch was protected by a ground fault circuit interrupter (GFCI), it could not be determined. The Maintenance Director then stated that he would find out if the outlet was protected, and if it was not then he would take appropriate steps to remedy the situation. During the exit conference with the facility Administrator, the R.D.P.O., and the Maintenance Director at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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	155219	A. BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 Social Services office did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 12 residents, 4 staff, and 2 visitors. Findings include: Based on observation made with the facility Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance Director during a tour of the facility at on 09/07/22 at 12:20 p.m., a power strip was in use in the Social Services office with a refrigerator and a microwave oven plugged into it. Based on an interview at the time of the observation, the Maintenance Director unplugged both items from the power strip and placed them in an existing outlet on the wall. This deficiency was removed prior to my exiting of the facility but was still discussed at the exit conference with the facility Administrator, the R.D.P.O., and the Maintenance Director at 2:45 p.m. 3.1-19(b)	K 0920	**K 920** **Electrical Equipment – Power Cords and Extension** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, inspected and maintained all electrical equipment in the facility in accordance with NFPA 99 and NFPA 70. b. Full facility inspection and maintenance of all electric equipment such as power cords and extension cords to meet the UL 1363A or UL 60601-1. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility inspection and maintenance of all electric equipment such as power	09/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	09/07/2022

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			cords and extension cords to meet the UL 1363A OR UL 60601-1. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Plant Operations Director/ Designee under the supervision of the Executive Director, will inspect and maintain all electric equipment in the facility to meet the NFPA 99 and NFPA 70 requirements weekly x4, monthly x6, and quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect and maintain all electric equipment in the facility to meet the NFPA 99 and NFPA 70 requirements weekly x4, monthly x6, and quarterly thereafter. b. Plant Operations Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further	

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			monitoring/action is necessary for continued compliance. **5. By what date the systemic changes for each deficiency will be completed.** a. 9/24/2022.	