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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219			JILDING	NSTRUCTION	COM	e survey Pleted 7/2022
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF SOUTH	I BEND		52654 N	NDDRESS, CITY, STATE, ZIP COI NIRONWOOD RD BEND, IN 46635	)	
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 0004 SS=C Bldg  Bldg  Bldg  E 0004 SS=C Bldg  Bldg  A004 SS=C Bldg  Bl	iana Department of Health in CFR 483.73.  22  0124 55219 56730  reparedness survey, Majestic was found not in compliance paredness Requirements for aid Participating Providers R 483.73  certified beds. At the time of s was 61.  pleted on 09/12/22  (a), 418.113(a), (a), 483.475(a), 483.73(a), 5(a), 485.68(a), 0(a), 486.360(a), a) Review and Update  54(a), §418.113(a), 84(a), §482.15(a), 75(a), §484.102(a), 25(a), §485.727(a), 360(a), §491.12(a),  omply with all applicable	E 00	000			

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

TITLE (X6) DATE

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	<u></u>	COMPL	ETED
		155219	B. W	ING		09/07/	/2022
	PROVIDER OR SUPPLIER  IC CARE OF SOUT  SUMMARY		•	52654 N	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635  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)	ATE	COMPLETION
TAG	preparedness required must develop estate comprehensive errorgram that mee section. The emer program must include the following elemical (a) Emergency Pladevelop and main preparedness planand updated at leamust do all of the "For hospitals at §485.625(a):] Emergency Planate (CAH] must develop comprehensive errorgram that mee section, utilizing a "For LTC Facilities Emergency Planate (For ESRD Facil Emergency Pl	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 apply with all applicable d local emergency uirements. The [hospital or up and maintain a mergency preparedness ts the requirements of this in all-hazards approach.  Bes 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.		TAG			DATE
		riew and interview, the facility d maintain an emergency	E 0	JU <del>4</del>	E 004  Development of Emergency		09/24/2022

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preparedness plan that was reviewed and updated

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**Preparedness Plan** 

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  09/07/2022
	OF PROVIDER OR SUPPLIE		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(X4) III PREFIX TAG	summary (EACH DEFICIENT REGULATORY OF at least annually in 483.73(a). This defoccupants.  Findings include:  Based on review of Preparedness Plant 9:40 a.m., document preparedness prograwithin the most recent available for reprovided had not be 12 months with the review being listed interview at the time Administrator said review the Emergenths time. During the facility Administrator Plant Operations, a 2:45 p.m., no additioned at least annually in the summary of the	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION accordance with 42 CFR ficient practice could affect all  If the facility's Emergency on 09/07/22 from 9:15 a.m. to ntation of an emergency am reviewed by the facility tent twelve-month period was view. The emergency plan een reviewed within the past elast documented date of as 07/28/21. Based on ne of record review, the that he had not had time to ncy Preparedness plan as of ne exit conference with the tor, the Regional Director of nd the Maintenance Director at ional information or evidence contrary to this deficient	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  1. What corrective action(will be accomplished for tho 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 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 Eplan.  3. What measures will be put into place and what systemic changes will be mat to ensure that the deficient practice does not recur; a. Plant Operations Direct Designee, under the supervisit the Executive Director, will revand update EP plan weekly xamonthly x6, and annually thereafter.  4. How the corrective action(s) will be monitored to support the corrective action(s) will be support the corr	the  the  the  d  final distribution of the di
	ĺ		1	ensure the deficient practice	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/07/2022
	ROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	-
(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
E 0013 SS=C Bldg	484.102(b), 485.6: 485.727(b), 485.9: 491.12(b), 494.62: Development of E §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).	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), 1.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),		will not recur, i.e., what qua assurance program will be pinto place; a. Plant Operations Director Designee, under the supervision the Executive Director, will reand update the EP plan week x4, monthly x6, and annually thereafter.  b. Plant Operations Director/Designee will report findings to the QAPI committe monthly for (6) six months. To QAPI committee will monitor data presented for any trends determine if further monitoring/action is necessal continued compliance.  5. By what date the system changes for each deficiency will be completed. a. 9/24/2022	audit ee the ts &  ry for

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JILDING	<del></del>	COMPL	
		155219	B. W	_		09/07	/2022
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
МД ІЕСТ	IC CARE OF SOUT	TH REND			N IRONWOOD RD I BEND, IN 46635		
	TO CARE OF 3001	TI BEND		300111	DEND, IN 40033		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG	i	icies and procedures, based		TAG			DATE
		plan set forth in paragraph					
		risk assessment at					
	paragraph (a)(1) o	of this section, and the					
		an at paragraph (c) of this					
	-	cies and procedures must					
		updated at least every 2					
	years.						
	*[For LTC facilities	s at §483.73(b):] Policies					
	_	The LTC facility must					
	develop and imple						
	preparedness poli	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.					
	De reviewed and t	apdated at least armually.					
	*Additional Requir	rements for PACE and					
	ESRD Facilities:						
	-	60.84(b):] Policies and					
		PACE organization must					
	develop and imple						
		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					
	-	nent of medical and					
	nonmedical emerg	gencies, including, but not					
	limited to: Fire; eq	uipment, power, or water					
	failure; care-relate	ed emergencies; and natural					
	-	threaten the health or					
		cipants, staff, or the public.					
		procedures must be					
	I reviewed and und	ated at least every 2 years	ı				I

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DEPARTMENT	OF HEALTH AND HU!	MAN SERVICES
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		A. BUILDING COMPL			ETED	
		155219	B. WI	NG		09/07/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIER	L			N IRONWOOD RD		
MA IEST	IC CARE OF SOUT	H BEND			BEND, IN 46635		
MAJEST	IC CARE OF 3001	II BEND		300111	BEND, IN 40033		
(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 CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For ESRD Facility and procedures. develop and imple preparedness polition the emergency (a) of this section, paragraph (a)(1) of communication plasection. The polition be reviewed and users. These emenot limited to, fire, failures, care-relat supply interruption likely to occur in the area.  Based on record reversible to develop an preparedness policies and procedupdated at least and CFR 483.73(b). This all residents in the femore are the facility within twelve-month periodorum the facility within twelve-month periodorum the documented date of 07/28/21. Based on reviewed within the documented date of 07/28/21. Based on review, the Administime to review the E	ties at §494.62(b):] Policies The dialysis facility must ement emergency cies 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 every 2 orgencies include, but are equipment or power red emergencies, water or, and natural disasters or facility's geographic  riew and interview, the facility d implement emergency es and procedures. These cures must be reviewed and ually in accordance with 42 as deficient practice could affect facility.  the facility's Emergency on 09/07/22 from 9:15 a.m. to tation of emergency es and procedures reviewed	E 00	013	E 013 Development of Emergency Preparedness Policies and Procedures 1. What corrective action(s) who is 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 potention be affected by the deficient practice. Full facility updates a	nd nt i	09/24/2022

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	 JILDING	ONSTRUCTION	(X3) DATE COMPL 09/07/	ETED
	PROVIDER OR SUPPLIEI		52654 I	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635		
(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)	TE	(X5) COMPLETION DATE
	Plant Operations, a	tor, the Regional Director of nd the Maintenance Director at ional information or evidence		development of EP policies ar procedures.	nd	
	_	contrary to this deficient		3. What measures will be put into place and what systemic changes will be mat to ensure that the deficient practice does not recur; a. Plant Operations Director/ Designee, under the supervisithe Executive Director, will revand 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 printo place; a. The 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.  b. Plant Operations Director/Designee will report a findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor to data presented for any trends determine if further	on of view  y  tity  ut  te the	

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monitoring/action is necessary for

continued compliance.

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		A. BUILDING B. WING	<del></del>	COMPLETED 09/07/2022		
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0029	403.748(c), 416.5			5. By what date the system changes for each deficiency will be completed. a. 9/24/2022.		
SS=C Bldg	441.184(c), 482.19 484.102(c), 485.69 485.727(c), 485.99 491.12(c), 494.620 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.9 §485.68(c), §485.19 §494.62(c).  (c) The [facility] man emergency preplan that complies local laws and mu	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),				
	Based on record rev failed to develop an preparedness comm with Federal, State,	riew and interview, the facility d maintain an emergency unication plan that complies and local laws in accordance 8(c). This deficient practice ipants.	E 0029	E 029 Development of Emergency Preparedness Communication Plan 1. What corrective action(s) to be accomplished for those residents found to have been	will	
	Preparedness Plan of 9:40 a.m., documen preparedness comm the facility within the preparedness community within the facility within the preparedness plan of the preparedne	the facility's Emergency on 09/07/22 from 9:15 a.m. to tation of emergency unication plan reviewed by the most recent twelve-month lable for review. The		affected by the deficient practice; a. Facility emergency Preparedness (EP) plan was developed, updated and maintained. a. Education of all staff on communication and	the	

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emergency plan provided had not been reviewed

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Implementation of the EP plan.

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	OF CORRECTION	IDENTIFICATION NUMBER  155219	A. BUILDING B. WING		COMPLETED 09/07/2022
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	07/28/21. Based on review, the Administime to review the E as of this time. Duri facility Administrat Plant Operations, ar 2:45 p.m., no additional review.	review being listed as interview at the time of record strator said that he had not had emergency Preparedness plan ing the exit conference with the for, the Regional Director of ad the Maintenance Director at conal information or evidence contrary to this deficient		2. How other residents having the potential to be affected by the same deficie practice will be identified at what corrective action(s) who be taken; a. All residents have the potential to be affected by the deficient practice. Full facility updates development of EP community.  3. What measures will be moderated to the put into place and what systemic changes will be moderated to ensure that the deficient practice does not recur; a. Plant Operations Director, under the supervision of the Executive Director, will revieu update EP communication poweekly x4, monthly x6, and annually thereafter.  4. How the corrective action(s) will be monitored ensure the deficient practice will not recur, i.e., what quates assurance program will be into place; a. Plant Operations Director, will recall the Executive Director the Executive Dir	ential int and ication  e  nade  to  e  ality put  tor/ sion of eview cation

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FOR MEDICARE & MEDIC.	AID SERVICES		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
	155219	B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD

MAJEST	TIC CARE OF SOUTH BEND	SOUTH	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 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	TAG	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.	DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/07/2022		
		PROVIDER OR SUPPLIEF		•	52654 N	ADDRESS, CITY, STATE, ZIP COD NIRONWOOD RD BEND, IN 46635	•	
(X4) PREI	FIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	(X5) COMPLETION
TA	G	section, policies a (b) of this section, plan at paragraph training and testin reviewed and upd  *[For LTC facilities and testing. The and maintain an e training and testin the emergency pla of this section, risi (a)(1) of this section at paragraph (b) of communication pl section. The train must be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing progra emergency plan s this section, risk a (a)(1) of this section at paragraph (b) of communication pl section. The train must be reviewed 2 years. The ICF/II requirements for eat §483.470(i).  *[For ESRD Facilit Training, testing, a dialysis facility mu emergency prepa and patient orients	and the communication (c) of this section. The g program must be ated at least every 2 years.  at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least  §483.475(d):] Training and D must develop and gency preparedness training am that is based on the eter forth in paragraph (a) of essessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least of this section, and the an at paragraph (c) of this hing and testing program and updated at least every IID must meet the evacuation drills and training  ties at §494.62(d):] and orientation. The list develop and maintain an redness training, testing ation program that is based or plan set forth in paragraph		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMP.					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155219	A. BU B. WI		<del></del>	COMPLETED 09/07/2022	
		133219	D. WI		_	09/07/	2022
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND			I BEND, IN 46635		
(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 CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	(a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation prograupdated at every 2 Based on record reversible for the preparedness training was reviewed and understood a could affect which are the process of the process of this time. During facility Administrat Plant Operations, at 2.45 p.m., no additi	risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) ne training, testing and m must be evaluated and 2 years. View and interview, the facility and maintain an emergency ng and testing program that appdated at least annually in CFR 483.73(d). This deficient	E 00		E 036 Training and Testing 1. What corrective action(s) to 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 potent 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.	nddd, / nt i ent g	09/24/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/07/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	the Executive Director, will revand update EP training and teprogram weekly x4, monthly x 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 printo place;  a. Plant Operations Director Designee, under the supervisity the Executive Director, will revand update the EP training antesting weekly x4, monthly x6, and annually thereafter.  b. Plant Operations Director/Designee will report a 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 continued compliance.  5. By what date the system changes for each deficiency will be completed. a. 9/24/2022.	sting 6  ty ut  or/ on of riew d  udit e e he & r for		
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484	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),					

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486.360(d)(2), 491.12(d)(2), 494.62(d)(2)

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	Γ OF HEALTH AND HUI R MEDICARE & MEDIC				FO	TED: 09/28/2022 RM APPROVED IB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIEF		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635			
(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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
	§460.84(d)(2), §44 §483.475(d)(2), §485.625(d)(2), §491.12(d)(2) *[For ASCs at §41 OPO, "Organizatic CMHCs at §485.9 §491.12, and ESF (2) Testing. The [fexercises to test t	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					

(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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIEI			52654 N	ADDRESS, CITY, STATE, ZIP COD NIRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	discussion using						
	1	emergency scenario, and a					
	set of problem statements, directed messages, or prepared questions designed						
	to challenge an e	·					
	_	acility'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	a full-scale exercise that is					
	community based	every 2 years; or					
	(A) When a comn	nunity based exercise is not					
	accessible, condu	ıct an individual facility					
	based functional	exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospital is					
		aging in its next required full					
	1	based exercise or individual					
	1	ctional exercise following the					
	onset of the emer	<del>-</del>					
	` '	dditional exercise every 2					
		ne year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	1 ' '	-scale exercise that is					
	1	l or a facility based					
	functional exercis						
	(B) A mock disas						
		ercise or workshop that is					
		and includes a group					
	discussion using	a narrateo,					I

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIER		52654 1	ADDRESS, CITY, STATE, ZIP COI N IRONWOOD RD I BEND, IN 46635	)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		(X5) COMPLETION	
TAG	clinically-relevant set of problem star messages, or preto challenge an erection care directly. The exercises to test the per year. The hose (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergof the emergency exempt from engafull-scale community functional exercise emergency event. (ii) Conduct an act that may include, following:  (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exfacilitator that inclusing a narrated, emergency scenastatements, direct questions designed emergency plan.	pared questions designed mergency plan.  spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise based; or nunity-based exercise is not act an annual individual ctional exercise; or 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 diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem and the determinant of the descale exercise and the problem are descaled to challenge an	TAG	DEFICIENCY		DATE	
	maintain documer exercises, and en	nospice's response to and ntation of all drills, tabletop nergency events and revise ergency plan, as needed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<del></del>	COMPLETED	
		155219	B. WIN	IG		09/07/	2022
NAME OF B	AD CLUBED OR CURPLUE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<b>C</b>		52654 N	N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND		SOUTH	BEND, IN 46635		
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§482.15(d), CAHs (2) Testing. The [F conduct exercises	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital,					
		ın annual full-scale exercise					
	that is community						
	, ,	nunity-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						
	•	ation of the emergency					
		s exempt from engaging in ull-scale community based					
		ty-based functional exercise					
		t of the emergency event.					
	` '	an [additional] annual					
		at may include, but is not					
	limited to the follow	_					
	community-based	scale exercise that is					
	facility-based fund						
	•	ck disaster drill; or					
	(C) A tabletor	exercise or workshop that					
		or and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
	-	pared questions designed					
	to challenge an er						
	_	ne [facility's] response to					
	and maintain documentation of all drills, tabletop exercises, and emergency events						
	_	cility's] emergency plan, as					
	needed.						

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\*[For PACE at §460.84(d):]

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		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155219	B. W		<del></del>	09/07		
		133219	D. W.			09/07/	2022	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
					N IRONWOOD RD			
MAJEST	IC CARE OF SOUT	TH BEND	_	SOUTH	I BEND, IN 46635			
(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	DEFICIENC!)		DATE	
		PACE organization must						
		s to test the emergency						
	plan at least annu							
	organization must	<del>-</del>						
		an annual full-scale exercise						
	that is community							
		nunity-based exercise is not						
		ıct an annual individual,						
	1	ctional exercise; or						
	, ,	xperiences an actual natural						
		ergency that requires						
		mergency plan, the PACE						
		gaging in its next required						
		nity based or individual,						
	I	ctional exercise following the						
	onset of the emer							
	, ,	in additional exercise every						
		the year the full-scale or						
		e under paragraph (d)(2)(i)						
		onducted that may include,						
	but is not limited to	_						
	, ,	scale exercise that is						
		or individual, a facility						
	based functional e							
	(B) A mock disas							
		ercise or workshop that is						
	· ·	and includes a group						
	discussion, using							
		emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er							
	, ,	PACE's response to and						
		ntation of all drills, tabletop						
		nergency events and revise						
	uie PACE's emerç	gency plan, as needed.						
	*[For LTC Facilitie	es at §483.73(d):]						
	-	ity] must conduct exercises						
		ency plan at least twice per						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155219	B. W			09/07	
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	TH BEND			I BEND, IN 46635		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	l '	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t						
		an annual full-scale exercise					
	that is community						
	1 ' '	nunity-based exercise is not					
	facility-based fund	ict an annual individual,					
	1	ility] facility experiences an					
	l ' '	nan-made emergency that					
		n of the emergency plan, the					
	-	mpt from engaging its next					
	_	ile community-based or					
		based functional exercise					
		et of the emergency event.					
	_	dditional annual exercise					
	1 ' '	but is not limited to the					
	following:						
		scale exercise that is					
		or an individual, facility					
	based functional e						
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
		LTC facility] facility's					
		naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[Ear   CE/IIDa at 9	3/92 /75/d)]·					
	*[For ICF/IIDs at §	· · · -					
	1 ' '	CF/IID must conduct					
		he emergency plan at least					
	following:	e ICF/IID must do the					
	ionowing.		1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155219	B. W		<del></del>	09/07	
		100210	В. "			03/01/	2022
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
MA IFOT	IC CARE OF SOUT	TH DEND			N IRONWOOD RD		
IVIAJEST	CARE OF 3001	H BEND		300111	I BEND, IN 46635		
(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 APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n annual full-scale exercise					
	that is community	-based; or nunity-based exercise is not					
	' '	ict an annual individual,					
		ctional exercise; or.					
	-	experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required					
	full-scale commur	nity-based or individual,					
	facility-based fund	tional exercise following the					
	onset of the emer	gency event.					
		ditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	' '	scale exercise that is					
	community-based						
	-	ctional exercise; or					
	(B) A mock disast						
	, ,	ercise or workshop that is					
	discussion, using	and includes a group					
		emergency scenario, and a					
	set of problem sta	•					
	1	pared questions designed					
	to challenge an er						
	_	CF/IID's response to and					
	1 ` '	ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	-					
		e HHA must conduct					
		he emergency plan at					
	· · · · · · · · · · · · · · · · · · ·	e HHA must do the					
	following:	full analy avancies that is					
		full-scale exercise that is					
	community-based						
	, ,	ommunity-based exercise conduct an annual					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	UILDING	NSTRUCTION		LETED 1/2022
	PROVIDER OR SUPPLIEI		52654 N	DDRESS, CITY, STATE, ZIP COD I IRONWOOD RD BEND, IN 46635	-	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	ON D BE DPRIATE	(X5) COMPLETION
TAG	individual, facility- every 2 years; or.  (B) If the HH natural or man-ma activation of the e exempt from enga full-scale commun facility based fund onset of the emer (ii) Conduct an ad years, opposite the functional exercis of this section is of include, but is not (A) A second community-based facility-based fund (B) A mock d	A experiences an actual ade emergency that requires emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the egency event. Iditional exercise every 2 the year the full-scale or e under paragraph (d)(2)(i) conducted, that may a limited to the following:	TAG	DEFICIENCY		DATE
	is led by a facilitat discussion, using clinically-relevant set of problem star messages, or pre to challenge an el (iii) Analyze the H maintain documel exercises, and en the HHA's emerger *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a papor workshop at lea exercise is led by group discussion, relevant emergen	tor and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. IHA's response to and intation of all drills, tabletop inergency events, and revise ency plan, as needed.  86.360] e OPO must conduct the emergency plan. The				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	, ,	ILTIPLE CONSTRUCTION ILDING <u></u> NG	(X3) DATE SURVEY COMPLETED 09/07/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	prepared question emergency plan. I actual natural or requires activation OPO is exempt for required testing e of the emergency (ii) Analyze the Ol maintain document exercises, and enthe [RNHCl's and needed.  *[RNCHIs at §403 (d)(2) Testing. The exercises to test to the RNHCl must do the sexercises to test to the total compared the sexercises in the sexercises of the sexercises and a sexercise of the sexercises and enthe RNHCl's emergand on record restailed to analyze the maintain document exercises, and emergand the sexercises, and emergand the sexercises of the sexercises and emergand the sexercises are sexercises.	is designed to challenge an if the OPO experiences an inan-made emergency that in of the emergency plan, the om engaging in its next exercise following the onset event.  PO's response to and intation of all tabletop inergency events, and revise OPO's] emergency plan, as	E 00.	E 039 Emergency Preparedness Testing Requirements 1. What corrective action(s) be accomplished for those residents found to have be affected by the deficient practice; a. The facility in collaboratior the fire department conducte	09/24/2022  o will  en  n with ed EP		
		on 09/07/22 from 9:15 a.m. to		plan testing exercises to ens proper responses from all sta			

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	OF CORRECTION	IDENTIFICATION NUMBER  155219	A. BUILDING B. WING		COMPLETED 09/07/2022
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(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
	facility-based exerce actual emergency even on interview at the the Administrator stated survey, he had not yndocument any type emergency prepared conference with the Regional Director of Maintenance Director	nentation of: a community or ise, a tabletop exercise, or an event could be provided. Based time of record review, the is that as of the time of this event had time to conduct and of exercises for his staff on inness. During the exit facility Administrator, the f Plant Operations, and the or at 2:45 p.m., no additional ence could be provided cient finding.		a. All staff education and participation of functional exercises that are facility-base community-based was completed.  All staff education and participation of mock disaster drills and tabletop exercises we completed.  How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken;  a. All residents have the potential to be affected by the deficient practice. Full facility testing exercises to ensure presponse.  What measures will be put into place and what systemic changes will be material to be affected by the deficient practice does not recur;  a. The Maintenance Director, under the supervision of the Executive Director, will conduct the supervision of the Executive Director, will be supervision of the Executive Dire	eted  vere  nt d I EP oper  ade  ct sed)

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AND PLAN OF CORRECTION IDENT  155.		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY  COMPLETED  09/07/2022	
	PROVIDER OR SUPPLIER TIC CARE OF SOUT		52654	N IRONWOOD RD H BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE		
K 0000				a. Plant Operations Director Designee, under the supervisis the Executive Director, will revand update the EP testing exercises weekly x4, monthly and annually thereafter.  b. Plant Operations Director/Designee will report a findings to the QAPI committe monthly for (6) six months. Th QAPI committee will monitor to data presented for any trends determine if further monitoring/action is necessary continued compliance.  5. By what date the system changes for each deficiency will be completed. a. 9/24/2022.	ion of view x6, audit see se she & y for mic	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 09/07  Facility Number: 0 Provider Number: AIM Number: 100  At this Life Safety 6	00124 155219 266730 Code survey, Majestic Care of and not in compliance with	K 0000			

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Medicare/Medicaid, 42 CFR Subpart 483.90(a),

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155219		A. BUILDING <u>01</u> B. WING		COMPLETED 09/07/2022		
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD 1 BEND, IN 46635		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protect Life Safety Code (L. This one-story facility Type V (111) constructions are sprinklered. The fact with smoke detection areas open to the condetectors hard wired installed in all residually powered emergency capacity of 103 beds	the and the 2012 edition of the etion Association (NFPA) 101, SC), and 410 IAC 16.2.  It was determined to be of fruction and was fully illity has a fire alarm system on in the corridors and in all rridor. The facility has smoke at to the fire alarm system ent sleeping rooms. The protected by a 150-kW diesel of generator. The facility has a study certified for Medicare and a census of 61 at the time				
	were sprinklered. The garage providing factors					
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
		155219	B. W	ING		09/07/	2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32: Based on observation failed to ensure 1 of soiled linen rooms of spaces by smoke resulted to be supported by smoke resulted to the support of the s	-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64  n Rooms lons) crage Rooms/Spaces eet) classified as Severe	K 0	321	K 321 Enclosures of Hazardous Ard 1. What corrective action( will be accomplished for those residents found to have been affected by the deficient practice; a. Plant Operations Director/ Designee, under the supervision the Executive Director, audited and repaired all hazardous are doors to ensure safe separation from other facility spaces.  2. How other residents having the potential to be affected by the same deficien practice will be identified and what corrective action(s) will be taken:	s) se n on of d ea on	09/24/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/07/2022		
NAME OF P	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 654 N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND		OUTH BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE APPR	TION LD BE ROPRIATE	(X5) COMPLETION DATE
IAU	time of observation, acknowledged the caforementioned haz self-close and latch the exit conference the R.D.P.O., and the p.m., no additional in the self-close are self-close and the p.m., no additional in the self-close are self-close and the self-close are self-	the Maintenance Director	IAU	a. All residents have the problem to be affected by the deficipractice. Full facility audit repairs of all hazardous a doors.  3. What measures will put into place and what systemic changes will be to ensure that the deficipractice does not recur; a. Plant Operation Director. Designee, under the superthe Executive Director, with and service all hazardous doors weekly x4, monthly annually thereafter.  4. How the corrective action(s) will be monitor ensure the deficient practive action(s) will be monitor ensure the deficient practice program will into place; a. Plant Operations/Designee, under the superthe Executive Director, with and service all hazardous doors weekly x4, monthly annually thereafter.  b. Plant Operations Director/Designee will repfindings to the QAPI commonthly for (6) six months QAPI committee will mone data presented for any tredetermine if further monitoring/action is necessarily and service and service and the program of the continued compliance.	cient s and rea  II be e made ent  or/ ervision of ill audit s area e x6, and  red to ctice quality be put  ervision of ill audit s area e x6 and  ort audit mittee s. The itor the ends &	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE C A. BUILDING B. WING	<u>- :                                   </u>		
	PROVIDER OR SUPPLIEI		52654	r address, city, state, zip cod I N IRONWOOD RD TH BEND, IN 46635	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=C Bldg. 01	in accordance with complying with the National Electric (National Fire Alar Records of system and testing are re 9.6.1.3, 9.6.1.5, Nased on observating failed to maintain that it had accurate accordance with the 2012 edition, Sectional Compactice could affect visitors within the firm as a constant of the findings include:  Based on observating the findings include:  Based on observating the findings include:  Based on observating at the control panel were main fire alarm control panel were main fire alarm control the section of the section	m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. In acceptance, maintenance adily available.  IFPA 70, NFPA 72 on and interview, the facility he fire alarm system to assure time and date information in e requirements of NFPA 101-ons 19.3.4 and 9.6 and NFPA 72 cions 14.1, 14.1.1. This deficient et all residents, staff, and facility.  On made with the facility Regional Director of Plant O.), and the Maintenance our of the facility at on 09/07/22 me and date on the fire alarm incorrect. The display on the atrol panel indicated the date 3rd at 17:26 Hrs. when the	K 0345	5. By what date the system changes for each deficiency will be completed. a. 9/24/2022  K 345 Fire Alarm System – Testing and Maintenance 1. What corrective action(s) where accomplished for those residents found to have been affected by the deficient practice; a. Plant Operations Director/Designee, under the supervision the Executive Director, tested, updated, and maintained all fir alarm system in the facility in accordance with the approved program requirements under the NFPA 70, National Electric coon NFPA 72, and National Fire Aland Signaling Code.	09/24/2022  vill  on of e  ne de,
1	_	07/22 and the time was 12:32		2 How other residents	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	he was unaware of contact the alarm of date and time updat panel as soon as he conference with the R.D.P.O., and the N.D.m., no additional	view at the time of aintenance Director indicated the discrepancy and would ompany to have the displayed sed on the fire alarm control could. During the exit of facility Administrator, the Maintenance Director at 2:45 information or evidence could by to this deficient finding.		having the potential to be affected by the same deficie practice will be identified an what corrective action(s) wi be taken;  a. All residents have the pote to be affected by the deficient practice. Full facility tests and updates of all fire alarm system to ensure the approved programing.  3. What measures will be put into place and what systemic changes will be must to ensure that the deficient practice does not recur;  a. Plant Operations Director/Designee, under the supervise the Executive Director, will te update, and maintain all fire a systems in the facility weekly 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 qualessurance program will be printo place;  a. Plant Operations Director, will the update, and maintain all fire a systems in the facility weekly monthly x6, and quarterly the Executive Director, will the update, and maintain all fire a systems in the facility weekly monthly x6, and quarterly thereafter.	ntial t t d minimum tor/ sion of st, alarm x4,	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155219	A. BUIL B. WING		01	COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIEI			52654 N	DDRESS, CITY, STATE, ZIP COD I IRONWOOD RD		
MAJEST	IC CARE OF SOUT	TH BEND	;	SOUTH	BEND, IN 46635		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System Spinkler System - 2012 EXISTING Nursing homes, a by construction ty throughout by an sprinkler system i 13, Standard for t Systems. In Type I and II co protection measus substituted for spi areas where state sprinklers. In hospitals, sprin clothes closets of where the area of 6 square feet and the closet footprin	Installation  nd hospitals where required		TAG	b. Plant Operations Director/Designee will report a findings to the QAPI committee monthly for (6) six months. Th QAPI committee will monitor to data presented for any trends determine if further monitoring/action is necessar continued compliance.  5. By what date the syste changes for each deficiency will be completed. a. 9/24/2022.	audit ee ne the s &	DATE

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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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVE  COMPLETED  09/07/2022			
	PROVIDER OR SUPPLIEF		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF failed to maintain the North Hall electrica	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The ceiling construction in 1 of 1 all closet #1 in accordance with The for the Installation of Sprinkler	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Sprinkler System Installation  1. What corrective action(s) he accomplished for those	n Jane
	Systems. NFPA 13, states plates, escute to cover the annular be metallic or shall sprinkler. This defice residents, 4 staff, and Findings include:  Based on observation of the Administrator, the Information of the Administrator, the Information of the Informat	for the Installation of Sprinkler, 2010 edition, Section 6.2.7.1 heons, or other devices used a space around a sprinkler shall be listed for use around a cient practice could affect 14 and 2 visitors.  On made with the facility Regional Director of Plant O.), and the Maintenance our of the facility at on 09/07/22 orth Hall electrical closet #1 had been the escutcheon and the Based on interview at the time Maintenance Director haware that the escutcheon must be ceiling and added that he taken care of as soon as he the issue. During the exit of facility Administrator, the Maintenance Director at 2:45 information or evidence could by to this deficient finding.		be accomplished for those residents found to have been affected by the deficient practice; a. Plant Operations Director/ Designee, under the supervisit the Executive Director, inspect updated, and maintained all sprinkler system in the facility accordance with the requirem under the NFPA 13, 2010 Edital 2. How other residents having the potential to be affected by the same deficie practice will be identified anywhat corrective action(s) will be taken; a. All residents have the potent to be affected by the deficient practice. Full facility inspection 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 matto ensure that the deficient practice does not recur; a. Plant Operations Director/ Designee, under the supervisit the Executive Director, will inspect, test, and maintain all sprinkler systems in the facility weekly x4, monthly x6, and quarterly thereafter.	ion of cted, in lents tion.  nt d ll ntial lens le

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>0</u> 1	(X3) DATE SURVEY COMPLETED 09/07/2022		
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD	•		
MAJEST	IC CARE OF SOUT	H BEND	SOUTH	H BEND, IN 46635			
(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	
TAG	REGULATORY			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 printo place; a. The Plant Operations Director/ Designee, under the supervision of the Executive Director, will inspect, test, and maintain all sprinkler systems the facility weekly x4, monthly and quarterly thereafter.  b. Plant Operations Director/Designee will report a findings to the QAPI committed monthly for (6) six months. The QAPI committee will monitor to data presented for any trends determine if further monitoring/action is necessary continued compliance.  5. By what date the system changes for each deficiency will be completed. a. 9/24/2022.	ity ut  in x6,  audit e e he & / for	DAIL	
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING	lding Spaces - Smoke lding Spaces - Smoke arriers are 1-3/4-inch thick					

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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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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 09/07/2022 155219 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0374 09/24/2022 K 374 failed to ensure 1 of 8 sets of smoke barrier doors **Subdivision of Building Spaces** would restrict the movement of smoke for at least - Smoke Barriers 20 minutes. LSC 19.3.7.8 requires doors in smoke 1. What corrective action(s) will barriers shall comply with LSC Section 8.5.4. LSC be accomplished for those 8.5.4.1 requires doors in smoke barrier shall close residents found to have been the opening leaving only the minimum clearance affected by the deficient necessary for proper operation. This deficient practice; practice could affect 24 residents, 6 staff, and 2 a. Plant Operations Director/ visitors. Designee, under the supervision of the Executive Director, inspected, repaired, and maintained all Findings include: smoke barriers in the facility in accordance with the NFPA 101 Based on observation made with the facility and Life Safety Code Administrator, the Regional Director of Plant Operations (R.D.P.O.), and the Maintenance How other residents Director during a tour of the facility at on 09/07/22 having the potential to be at 1:46 p.m., the set of smoke barrier doors nearest affected by the same deficient to Resident room #122 could not close completely practice will be identified and due to a reclining chair being stored between the what corrective action(s) will doors. Based on interview at the time of be taken: observations, the Maintenance Director a. All residents have the potential acknowledged these smoke barrier doors could to be affected by the deficient not close completely because the chair obstructed practice. Full facility inspections them and immediately removed the chair to a and repairs of all smoke barriers to proper storage location removing the issue. This ensure that all code requirements deficiency was removed prior to my exiting of the are met. facility but was still discussed at the exit conference with the facility Administrator, the What measures will be R.D.P.O., and the Maintenance Director at 2:45 put into place and what p.m. systemic changes will be made

to ensure that the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/07/2022		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND			BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
	·				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	practice does not recur; a. Plant Operations Director/ Designee, under the supervis the Executive Director, will inspect, repair, and maintain smoke barrier doors in the face 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 qual assurance program will be point or place; a. Plant Operations Direct Designee, under the supervise the Executive Director, will inspect, repair, and maintain as moke barrier doors in the face weekly x4, monthly x6, and quarterly thereafter.  b. Plant Operations Director/Designee will report findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor data presented for any trends determine if further	ion of all cility  o e lity out tor/ cion of all cility audit ee ne the s &	DATE
					monitoring/action is necessar continued compliance.  5. By what date the syste changes for each deficiency will be completed. a. 9/24/2022.	mic	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
155219		B. W	B. WING		09/07/2022			
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
K 0511	NFPA 101							
SS=E	Utilities - Gas and	Electric						
Bldg. 01	Utilities - Gas and	Electric						
	Equipment using (	gas or related gas piping						
	complies with NFF	PA 54, National Fuel Gas						
		iring and equipment						
	complies with NFF	PA 70, National Electric						
	_	tallations can continue in						
	service provided n							
	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							
				511	K 511		09/24/2022	
					Utilities – Gas and Electric			
					1. What corrective action(s)	will		
	(GFCI) protection against electric shock. LSC				be accomplished for those			
	19.5.1.1 requires utilities comply with Section 9.1.				residents found to have beer	า		
	LSC 9.1.2 requires electrical wiring and equipment				affected by the deficient			
	to comply with NFPA 70, National Electrical Code.				practice;			
	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				a. Plant Operations Director/			
					Designee, under the supervisi			
					the Executive Director, inspec			
					and maintained all electrical w			
					in the facility in accordance wi			
					NFPA 70 and National Electric	cal		
	accessible location.				Code.			
		velling Units. All 125-volt,			a. Full facility inspection an			
		and 20-ampere receptacles			maintenance of all electric out			
	installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.				within 6ft of wet locations to ha	ave		
					ground fault circuit interrupter	ماد		
		rotection for personner.			protection against electric shock.			
	(1) Bathrooms				2. How other residents			
	(2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are							
					having the potential to be	nt		
					affected by the same deficient practice will be identified and			
	_	le and are supplied by a			what corrective action(s) will			
	•	eated to electric snow-melting,			be taken;	1		
		and vessel heating equipment			a. All residents have the poter	ntial		
					to be affected by the deficient			
	shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.				practice. Full facility inspection			
	Exception No. 2 to (4): In industrial establishments				and maintenance of all electric			
Exception 110. 2 to (1). In moustrial establishments		1		I amandananoo or an olootiit	-	ı		

CENTERS F	OR MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	01	COMPI	ETED		
155219		B W	B. WING		09/07/2022			
100210			D			00/01/	ZUZZ	
NAMEO	F PROVIDER OR SUPPLIE	2		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME O	I TROVIDER OR SOTTEIET			52654 I	N IRONWOOD RD			
MAJES	STIC CARE OF SOUT	TH BEND		SOUTH	H BEND, IN 46635			
77.0.75					1		1 775	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX				PREFIX			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	only, where the cor	nditions of maintenance and			outlets within 6ft of wet location	ns		
	supervision ensure	that only qualified personnel			to have ground fault circuit			
	are involved, an ass	sured equipment grounding			interrupter protection against	errupter protection against		
		as specified in 590.6(B)(2)			electric shock.			
		For only those receptacle						
	_	ply equipment that would			3. What measures will be			
		ard if power is interrupted or			put into place and what			
	_	t is not compatible with GFCI			1 -	do		
		a is not compande with GrCi			systemic changes will be ma	iue		
	protection.				to ensure that the deficient			
	1 1	eceptacles are installed within			practice does not recur;			
	· · · ·	outside edge of the sink.			a. Plant Operations Director/	_		
	Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater				Designee, under the supervisi	on of		
					the Executive Director, will			
					inspect, repair, and maintain a	all		
	hazard shall be peri	mitted to be installed without			electric wirings and outlets in t	the		
	GFCI protection.				facility to meet the NFPA 70 a	nd		
	Exception No. 2 to	(5): For receptacles located in			National Electric Code			
		as of general care or critical			requirements weekly x4, mont	hlv		
	1 -	care areas of health care facilities other than those			x6 and quarterly thereafter.	,		
	covered under				, we are quarterly are carren			
		protection shall not be required.			4. How the corrective			
	(6) Indoor wet loca				action(s) will be monitored to	•		
	` '	with associated showering			1			
	facilities	itii associated showeilig			ensure the deficient practice			
		a have and similar			will not recur, i.e., what quali	_		
		e bays, and similar areas where			assurance program will be p	ut		
	1	c equipment, electrical hand			into place;	,		
	tools.				a. Plant Operations Direct			
		Wet Locations, requires all			Designee, under the supervisi	on of		
	_	ed equipment within the area of			the Executive Director, will			
	the wet location to have ground-fault circuit				inspect, repair, and maintain a	all		
	interrupter (GFCI)	protection. Note: Moisture can			electric wirings and outlets in t	the		
	reduce the contact i	resistance of the body, and			facility to meet the NFPA 70 a	nd		
	electrical insulation	is more subject to failure. This			National Electric Code			
	deficient practice could affect staff while at the hand washing sink in the North nurse's station				requirements weekly x4, mont	hly		
					x6 and quarterly thereafter.	,		
	Med room.							
	11100 100111.				b. Plant Operations			
	Findings include:				Director/Designee will report audit			
	rindings include:				-			
					findings to the QAPI committe	е	1	

Based on observation made with the facility

monthly for (6) six months. The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  09/07/2022	
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(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
K 0920 SS=E Bldg. 01	Operations (R.D.P.O. Director during a to at 1:46 p.m., the No had a hand-washing switch for this room from the water sour when asked if the sy ground fault circuit be determined. The stated that he would protected, and if it wappropriate steps to the exit conference the R.D.P.O., and the p.m., no additional is be provided contrart.  3.1-19(b)  NFPA 101  Electrical Equipment Extens  Extens  Electrical Equipment Extens  Electrical Equipment Extens  Extens  Electrical Equipment Extens  Electrical Equipment Extens  Extens  Extens  Electrical Equipment Extens  Extens  Electrical Equipment Extens  Extens  Extens  Electrical Equipment Extens  Extens  Extens  Electrical Equipment Extens  Electrical Equipment Extens  Extens  Electrical Equipment Extens  Extens  Electrical Equipment Exte	Regional Director of Plant D.), and the Maintenance our of the facility at on 09/07/22 orth nurses station Med room sink located within. The light awas approximately 43 inches on the Based on an interview, witch was protected by a interrupter (GFCI), it could not Maintenance Director then find out if the outlet was was not then he would take remedy the situation. During with the facility Administrator, are Maintenance Director at 2:45 information or evidence could by to this deficient finding.  The Power Cords and the Power Cords and the Power Cords and the state of movable in the state of the st		QAPI committee will monitor the data presented for any trends determine if further monitoring/action is necessary continued compliance.  5. By what date the system changes for each deficiency will be completed. a. 9/24/2022.	& r for

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1P7M21

Facility ID: 000124

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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 <u>01</u> CO		COMPI	COMPLETED	
155219		155219	B. WING			09/07/2022	
NAME OF PROPERTY OF STREET				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER				52654 I	N IRONWOOD RD		
MAJESTIC CARE OF SOUTH BEND				SOUTH	H BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION  precautions. Extension	+	TAG			DATE
		d as a substitute for fixed					
		re. Extension cords used					
	temporarily are removed immediately upon completion of the purpose for which it was						
	•	ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	,	(D) (NFPA 70), TIA 12-5					
	Based on observation	on and interview, the facility	K 0	920	K 920 Electrical Equipment – Power		09/24/2022
	failed to ensure 1 or	f 1 Social Services office did					
	not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and				Cords and Extension		
					1. What corrective action(	s)	
	equipment shall be in accordance with NFPA 70,				will be accomplished for tho		
	National Electrical Code. NFPA 70, 2011 Edition,				residents found to have been	า	
	Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be				affected by the deficient		
	_				practice;		
		for fixed wiring of a structure.			a. Plant Operations Director/		
	_	ice could affect 12 residents, 4			Designee, under the supervisi		
	staff, and 2 visitors	•			the Executive Director, inspec	ted	
	Findings include:				and maintained all electrical		
	Findings include.				equipment in the facility in accordance with NFPA 99 and	4	
	Based on observation made with the facility				NFPA 70.	4	
		Regional Director of Plant			b. Full facility inspection an	ıd	
		O.), and the Maintenance			maintenance of all electric		
		our of the facility at on 09/07/22			equipment such as power core	ds	
		wer strip was in use in the Social			and extension cords to meet t	he	
		a refrigerator and a microwave			UL 1363A or UL 60601-1.		
		t. Based on an interview at the					
	time of the observation, the Maintenance Director				2. How other residents		
		ns from the power strip and			having the potential to be		
	^	xisting outlet on the wall. This			affected by the same deficien		
	I	oved prior to my exiting of the			practice will be identified and		
	1 *	I discussed at the exit			what corrective action(s) will	I	
		e facility Administrator, the Maintenance Director at 2:45			be taken; a. All residents have the		
		viaintenance Director at 2:43			a. All residents have the potential to be affected by the		
	p.m.				deficient practice. Full facility		
	3.1-19(b)				inspection and maintenance o	f all	
					electric equipment such as po		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219  A. BUILDING 01 COM 09/0  B. WING STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD	TE SURVEY PLETED 17/2022  (X5)	
NAME OF PROVIDER OR SUPPLIER  52654 N IRONWOOD RD		
MAJESTIC CARE OF SOUTH BEND SOUTH BEND, IN 46635		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  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 93 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 93 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 &	DATE	

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determine if further

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### $\label{eq:department} \textbf{DEPARTMENT OF HEALTH AND HUMAN SERVICES}$

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ENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building 01			COMPLETED	
		155219	B. WING			09/07/2022	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		E CO	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					monitoring/action is necessary continued compliance.	for	
					<ol><li>By what date the syster changes for each deficiency will be completed.</li></ol>	nic	

a. 9/24/2022.

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