STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING -- B. WING	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/12/23 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Emergency Preparedness survey, Majestic Care of North Vernon was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 110. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 06/13/23	E 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/26/2023.** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

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

Phil Ford | Executive Director | 06/21/2023

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

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

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

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on observation and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility at 9:45 a.m. on 06/12/23, the "overcrank" status indicator light for the wall mounted remote annunciator panel located at the C Hall nurse's station was illuminated in red indicating system trouble. The Maintenance Director tried to reset the annunciator panel indicator light by pushing the reset button on the panel but the status indicator light remained illuminated in red. The facility's diesel fired emergency generator located outside the facility on the south side of the grounds was not in operation. Based on interview at the time of the observations, the Maintenance Director stated he was not aware of any generator issues and stated the emergency generator would start if the building were to lose power but agreed the "overcrank" status indicator light for the wall mounted remote annunciator panel was illuminated. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the "overcrank" status indicator light remained	E 0041	K041-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. The 3-position switch has been cleaned and is operating as it should following this service. 2. A new 3-position switch has been ordered and will be installed when received. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Annunciator Panel has been added to the Maintenance Supervisor’s ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to	06/26/2023

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	illuminated. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.		ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Annunciator Panel 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/12/23 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Life Safety Code survey, Majestic Care Of North Vernon was found not in compliance with Requirements for Participation in	K 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 06/26/2023.** **The facility respectfully**	

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. All 61 resident sleeping rooms were surveyed. The facility has a capacity of 120 and had a census of 110 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review conducted on 06/13/23		**requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility.	K 0211	K211-E What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. The drain line, electrical cord and the dehumidifier units	06/26/2023

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, two separate dehumidifiers were in operation and were stored in the corridor outside Room B107 and Room B108. Each dehumidifier was stored up against the corridor wall opposite one another and each dehumidifier extended 20 inches into the corridor. Based on interview at the time of the observations, the Maintenance Director stated a sprinkler pipe in the attic above the corridor outside Room B107 had a water leak this past Friday. The leak had been temporarily repaired but the dehumidifiers were needed to dry out the corridor ceiling outside the rooms. The Maintenance Director stated the corridor width outside the rooms is eight feet wide and agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		have been removed from the building. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Unobstructed Hallways for proper egress has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Unobstructed Hallways for proper egress 5 days a week for 2	

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			weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4	K 0324	K324-D What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/26/2023

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	states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect over two staff in the kitchen. Findings include: Based on review of the kitchen range hood inspection contractor's "Invoice" documentation dated 06/08/23 with the Maintenance Director during record review from 9:50 a.m. to 12:40 p.m. on 06/12/23, documentation of a semiannual kitchen exhaust system inspection six months prior to 06/08/23 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed documentation		The Range Hood Cleaning documentation shows a record of the past completed cleanings indicating this Range Hood was also cleaned on 3/2/2023. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Range Hood Cleaning documentation has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his	

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	of a semiannual kitchen exhaust system inspection six months prior to 06/08/23 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the kitchen range hood inspection contractor had affixed an inspection sticker to the range hood which only displayed the most recent inspection on 06/08/23. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		designee, will review the Range Hood Cleaning documentation 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0345 SS=F 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 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. NFPA 72, Section 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is	K 0345	K345-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Repair documentation for Annunciator failure has been acquired confirming the identified repairs needed during the formal inspection have been completed. 2. Repair documentation for	06/26/2023

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	impaired. NFPA 72, Section 10.19.2 states a record shall be maintained by the system owner or their designated representative for a period of 1-year from the date the impairment is corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection" documentation dated 08/08/22 with the Maintenance Director during record review from 9:50 a.m. to 12:40 p.m. on 06/12/23, the remote annunciator for the facility's fire alarm system failed testing. The "Remarks/Comments" section of the 08/08/22 inspection report stated "Annunciator Failed". Repair or replace documentation for the fire alarm system annunciator was not available for review. Review of the "Remarks/Comments" section of the fire alarm system inspection contractor's "Fire Alarm Inspection" documentation dated 11/25/22 stated "Annunciator failed last inspection". Based on interview at the time of record review, the Maintenance Director stated the annunciator passed subsequent functional testing conducted on 02/14/23 and 05/16/23 but agreed repair or replacement documentation for the annunciator on or after 08/08/22 was not available for review at the time of the survey. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems		Smoke Detector failures has been acquired confirming the identified repairs needed during the formal inspection have been completed. 3. The Fire Panel Internal Clocks have been adjusted so they show the correct time. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Repair Documentation has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his	

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	was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection" documentation dated 08/08/22 with the Maintenance Director during record review from 9:50 a.m. to 12:40 p.m. on 06/12/23, four smoke detectors failed sensitivity testing. The "Remarks/Comments" section of the 08/08/22 inspection report stated "Four smoke detectors...failed". The 08/08/22 inspection report identified the four smoke detector locations as "O/S Conference RM", "Hall by Courtyard North", "O/S Vending Machine" and "O/S Social Service Office". Repair or replace documentation for the four smoke detectors which failed sensitivity testing on or after 08/08/22 was not available for review. Review of the		designee, will review the Repair Documentation 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	

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	"Remarks/Comments" section of the fire alarm system inspection contractor's "Fire Alarm Inspection" documentation dated 11/25/22 stated "Smoke Detectors failed sensitivity and need replaced". The 11/25/22 fire alarm system inspection report identified the same smoke detector locations which failed 08/08/22 sensitivity testing. Based on interview at the time of record review, the Maintenance Director stated the four smoke detector locations passed subsequent functional testing conducted on 02/14/23 and 05/16/23 but agreed repair or replacement documentation for the four smoke detector locations on or after 08/08/22 was not available for review at the time of the survey. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 3. 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. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the time of day for the main fire alarm control panel was incorrect. The display read the time of day as 2:56 p.m. at 1:31 p.m. The time of day for the remote fire panel located in the main entrance lobby was also			

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	incorrect. The display for the remote fire alarm panel read the time of day as 4:32 p.m. at 3:07 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the main fire alarm control panel and the remote fire alarm panel did not display the correct time of day. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 61 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 50 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the drain line and the electrical cord for an operating dehumidifier stored in the corridor outside Room B108 was taped to the floor and to the corridor door to resident sleeping Room B108. Room B108 was occupied by a resident and the corridor door to Room B108 was in the fully open position and was prevented from closing by the drain line and the electrical cord. In addition, a one half inch in diameter hole was noted in the corridor door to resident sleeping Room C107 just above the door handle which would not resist the passage of smoke.	K 0363	K363-E What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. The one-half inch hole in the corridor door for room C107, just above the handle, has been appropriately repaired. 2. The drain line, electrical cord and the dehumidifier units have been removed from the building How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into	06/26/2023

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	Based on interview at the time of the observations, the Maintenance Director agreed the drain line and the electrical cord prevented the corridor door to Room B108 from closing and latching into the door frame the hole in the corridor door to Room C107 would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Fire Panel Internal Clocks has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Fire Panel Internal Clocks 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This			

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	information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure all fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:50 a.m. to 12:40 p.m. on 06/12/23, current inspection certificates from the State of Indiana for all fuel fired water heaters in the facility were not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the following fuel fired heaters did not have current Certificate of Inspection documentation from the State of Indiana: a. the fuel fired water heater identified as IN266152. b. the fuel fired water heater identified as IN349205. c. the fuel fired water heater identified as IN370483. Based on interview at the time of the observations, the Maintenance Director stated current Certificate of Inspection documentation should have been in the Life Safety Code book for the facility but agreed the aforementioned fuel fired heaters did not have current Certificate of Inspection documentation from the State of Indiana.	K 0500	K500-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Pressure Vessel Certificates were discovered after Surveyor left the facility. They show that all units are up to date. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Pressure Vessel Certificates documentation has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned.	06/26/2023

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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Pressure Vessel Certificates documentation 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift and third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors.	K 0712	K712-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/26/2023

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	Findings include: Based on review of Direct Supply TELS: "Fire Drills" and "Fire Drill Report" documentation with the Maintenance Director during record review from 9:50 a.m. to 12:40 p.m. on 06/12/23, documentation of a fire drill conducted on the second shift in the fourth quarter (October, November, December) 2022 was not available for review. In addition, documentation of a fire drill conducted on the third shift in the first quarter (January, February, March) 2023 was also not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed documentation of a fire drill conducted on the second and third shifts in the aforementioned calendar quarters was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		The Fire Drill Schedule has been corrected indicating the need for 1 drill per shift per quarter at a minimum. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Fire Drill Schedule has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Fire Drill Schedule 5 days a week for 2 weeks, then weekly for 6 weeks,	

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			then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Section 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of	K 0761	K761-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Fire Door Inspection documentation has been updated showing the itemized list which now includes reviewing all Fore Doors in the area scheduled for inspection. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Fire Door Inspection has been added to the	06/26/2023

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	either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Doors, Locks and Alarms: Test Operation of Doors and Locks" documentation with the Maintenance Director during record review from 9:50 a.m. to 12:40 p.m. on 06/12/23, fire door inspection documentation for the facility within the most recent twelve months was not itemized by location. In addition, it was unclear if the inspection documentation included all items listed in NFPA 80, Section 5.2.4.2. The		Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Fire Door Inspection 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	

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	aforementioned TELS Logbook documentation was a daily inspection of doors listed in the "a hall", "b hall", "c hall" and "d hall". As a result, it was unclear if the inspection documentation was for fire door locations in each of the four halls or was for all door locations in the four halls. Based on interview at the time of record review, the Maintenance Director stated additional fire door inspection documentation was not available for review and agreed the TELS Logbook Documentation was not itemized by fire door location. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the corridor door to the oxygen storage and transfilling room by the southwest exit door of the facility in the service hall was equipped with a 1-hour fire resistance rating label. Four liquid oxygen containers and twenty 'E' type oxygen cylinders were stored in the room. The corridor door to the oxygen storage and transfilling room is not in one of the four halls identified in the TELS Logbook documentation. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals			

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	defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the	K 0914	K914-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Electrical Receptacle Testing has been and will continue to be performed at least annually at patient bed locations. A new schedule has been put into place. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into	06/26/2023

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(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
	grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Maintenance Director from 9:50 a.m. to 12:40 p.m. on 06/12/23, annual electrical receptacle inspection and testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed electrical receptacle inspection and testing documentation within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, resident sleeping rooms have non-hospital grade receptacles installed in the room. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. The Electrical Receptacle Testing Inspection has been added to the Maintenance Supervisor's ongoing inspection schedule. 2. Ongoing review by the ED, or his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Electrical Receptacle Testing Inspection 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	06/12/2023

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	generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels was in proper operating condition. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility at 9:45 a.m. on 06/12/23, the "overcrank" status indicator light for the wall mounted remote annunciator panel located at the C Hall nurse's station was illuminated in red indicating system trouble. The Maintenance Director tried to reset the annunciator panel indicator light by pushing the reset button on the panel but the status indicator light remained illuminated in red. The facility's diesel fired emergency generator located outside the facility on the south side of the grounds was not in operation. Based on interview at the time of the observations, the Maintenance Director stated he was not aware of any generator issues and stated the emergency generator would start if the building were to lose power but agreed the "overcrank" status indicator light for the wall mounted remote annunciator panel was illuminated. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 06/12/23, the "overcrank" status indicator light remained illuminated.	K 0916	K916-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. The 3-position switch has been cleaned and is operating as it should following this service. 2. A new 3-position switch has been ordered and will be installed when received. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All Residents residing in the facility could be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Inspection of the Annunciator Panel has been added to the Maintenance Supervisor’s ongoing inspection schedule. 2. Ongoing review by the ED, or	06/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		his designee, will be performed to ensure scheduled inspections are being completed and followed up on as planned. 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? 1. For Quality Assurance, the Maintenance Supervisor, or his designee, will review the Annunciator Panel 5 days a week for 2 weeks, then weekly for 6 weeks, then monthly for an additional 4 months. 2. Findings will be reported to the ED and the QA Committee for 6 months and will continue until 100% compliance has been achieved.	