STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING -- B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

(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: 05/15/23 Facility Number: 000477 Provider Number: 155570 AIM Number: 100290860 At this Emergency Preparedness survey, Majestic Care of McCordsville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 48 certified beds. At the time of the survey, the census was 34. Quality Review completed on 05/22/23	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 6-15-23 to the life safety survey completed on 5-15-2023. We respectfully request a paper review and will provide any additional information requested.	
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: 05/15/23 Facility Number: 000477 Provider Number: 155570 AIM Number: 100290860 At this Life Safety Code survey, Majestic Care of McCordsville was found not in compliance with	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 6-15-23 to the life safety survey completed on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katlyn Collins	HFA	06/23/2023

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in resident Room 22. The facility has battery operated smoke detectors in 20 of 21 resident sleeping rooms. The facility has a capacity of 48 and had a census of 34 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has an unsprinklered, detached 2 story wood frame pole barn housing a sprinkler system water storage tank and fire pump; an unsprinklered, detached 2 car garage used for oxygen storage; and an unsprinklered, 2 story wood barn used for housing a lawn mower and tractor and a snow blower. Quality Review completed on 05/22/23		5-15-2023. We respectfully request a paper review and will provide any additional information requested.	
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number			

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	of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	Based on record review, observation and interview; the facility failed to ensure the building construction type for the two-story portion of the facility was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 prohibits a two story sprinklered building to be of Type V(000) construction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0161	**It is the responsibility of the facility to ensure that the building construction type for the two-story portion of the facility is permitted.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected.	06/30/2023

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	Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the two-story portion of this fully sprinklered building had exposed wood as the structural element for the exterior load bearing wall and an interior load bearing wall in the sprinkler riser room in the basement. In addition, the top portion of the stairwell wall in the attic had exposed wood with one half inch thick plaster covering the interior portion of the stairwell wall. Residents have customary access to the dining room and the therapy room on the first floor of the two-story portion of the facility. Based on interview at the time of record review and of the observations, the Executive Director stated this had been a problem at the last survey and provided a copy of the previous FSES. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QAPI committee will monitor the on-going implementation of current facility policy and procedures to ensure appropriate and consistent implementation, which meet the standards and quality of care needs for the facility and the residents.	
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			

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	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 interview and observation the facility failed to maintain the required headroom space in the basement area. LSC section 7.1.5.1 states that the Means of egress shall be designed and maintained to provide headroom in accordance with other sections of this Code, and such headroom shall be not less than 7 feet 6 inches, with projections from the ceiling not less than 6 feet 8 inches with a tolerance of -3/4 inches, above the finished floor, unless otherwise specified by any of the following: (1) In existing buildings, the ceiling height shall be not less than 7 feet from the floor, with projections from the ceiling not less than 6 feet 8 inches nominal above the floor. (2) Headroom in industrial equipment access areas as provided in 40.2.5.2 shall be permitted. This deficient practice could affect up to 5 staff in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., in (1) the Oil Furnace Room and (2) Basement Storage area the ceiling height was below the required minimum height. The Maintenance Director, who stated he was approximately 6 feet tall stood underneath and acknowledged that the ceiling was close to his head. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the	K 0211	**It is the responsibility of the facility to ensure that the facility maintains the required headroom space in the basement area.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality**	06/30/2023

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	Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**assurance program will be put into place:** QAPI committee will monitor the on-going implementation of current facility policy and procedures to ensure appropriate and consistent implementation, which meet the standards and quality of care needs for the facility and the residents.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the			

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	building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure all exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which	K 0222	**It is the responsibility of the facility to ensure that all exit doors are provided with only one latching mechanism.**	05/30/2023

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	states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 6 occupants in the therapy area. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the (1) Nursing office Door and the (2) Exit door to the outside from the basement area were equipped with two latching devices, a regular locking door handle and a deadbolt latching mechanism. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 resident room doors were arranged such that staff can rescue residents in an emergency if the door become locked. This deficient practice could affect 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director		**The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The nursing office door and exit door to the outside from the basement were equipped with two latching devices (deadbolts removed) Room #11 functioning lock was removed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The nursing office door and exit door to the outside from the basement were equipped with two latching devices (deadbolts removed) Room #11 functioning lock was removed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will tour bldg monthly for 6 months to assure all doors only have one latching mechanism to	

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	and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the corridor door to resident room # 11 had a functioning lock. When asked, no key was available, and the Maintenance Director and Executive Director stated they were unaware the door had a lock on it. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		release the door and open. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting\.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 1 stairway enclosure door was in accordance with 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. This deficient practice affects 15 including staff and visitors. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the latch on the second floor stairwell exit door was not functioning and the door failed to latch. Additionally, there were holes approximately ¾" in diameter in the door near the	K 0225	**It is the policy for the protection of residents that the facility ensure all enclosure door requires a latch or other fastening device on a door leaf.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential for	06/30/2023

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	latching hardware. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		being affected by the deficient practice, but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** A quote to replace the exit stairwell door was received and a replacement door was ordered. All other doors were audited in the facility to ensure there was no impediments to latching into the door frame. No other doors were identified. **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?** The maintenance director or their designee will audit doors bi weekly x4 weeks weekly x4 weeks and monthly x4 months. All negative findings will be immediately remedied and brought to the ED's attention The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.	
K 0232 SS=F Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING			

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	The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 1. Based on observation, the facility failed to meet the clear width requirement for 1 of 3 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8	K 0232	**It is the responsibility of the facility to ensure that the corridors meet the width requirements.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality**	06/30/2023

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	This deficient practice could affect all residents, staff and visitors. Findings: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., near Room 10b, a large patient scale was being stored in the corridor and narrowed the width of the corridor below the required width. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 2. The facility failed to maintain the required corridor width throughout the facility. LSC 19.2.3.4* states any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as a means of egress from patient sleeping rooms. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., The ramp and adjacent stairs measured 35 inches (ramp) and 33 inches (steps) in width. The Maintenance Director measured the widths of both the ramp and steps. Additionally, the aforementioned ramp which is approximately 15-20 feet in length, did not appear to this surveyor to meet the overall slope requirement for existing facilities which is 1 inch of fall for every 6 inches of rise. The Executive Director stated that		**assurance program will be put into place:** QAPI committee will monitor the on-going implementation of current facility policy and procedures to ensure appropriate and consistent implementation, which meet the standards and quality of care needs for the facility and the residents.	

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	155570	A. BUILDING 01 B. WING	05/15/2023

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	the ramp seemed also seemed excessively steep to her. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3. The facility failed to keep all resident room corridors free from obstructions, trip hazards and obstacles as they exit the resident rooms. LSC 19.2.3.5 states that the aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., The ramp in front of Resident Room 211 crossed in front of the residents room and contained at least a 2 inch drop creating an unsafe condition for nonambulatory residents. The Executive Director stated during the facility tour that nonambulatory residents occasionally reside in room 211. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)			

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K 0241 SS=E Bldg. 01	NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 Based on observation and interview, the facility failed to provide the required number of exits from the basement area. LSC 19.2.4.4 states that not less than two exits shall be accessible from each smoke compartment, and egress shall be permitted through an adjacent compartment(s), provided that the two required egress paths are arranged so that both do not pass through the same adjacent smoke compartment. This deficient practice could affect up to 5 staff in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., in the basement only one means of egress was provided. There appeared to be only one way into and one way out of the basement area. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)	K 0241	**It is the responsibility of the facility to ensure that the required number of exits from the basement area exist.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents affected. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted.	06/30/2023

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: QAPI committee will monitor the on-going implementation of current facility policy and procedures to ensure appropriate and consistent implementation, which meet the standards and quality of care needs for the facility and the residents.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05	K 0291	**It is the responsibility of the facility to ensure that the exterior emergency lighting for all exits are equipped to work during power failure. Exterior exit lighting will be hooked to generator.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.**	06/15/2023

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	p.m. and 2:20 p.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. The Maintenance Director and the Executive Director were unsure and no further verification or documentation to verify the facilities exit lighting was connected to the generator and could illuminate in the event of a power outage. The Maintenance Director stated that he was pretty sure the lights were not connected to the generator. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		All residents have the potential to be affected but none were identified. The exterior emergency lighting was hooked to generator in case of power failure. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The exterior emergency lighting was hooked to generator in case of power failure. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will audit the exterior lighting monthly x 6 months to assure lighting is confirmed if power fails. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting\. Executive Director to monitor.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting			

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	partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 3 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 22 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) The upstairs medical records room contained	K 0321	**It is the responsibility of the facility to ensure that corridor doors for hazardous areas, such as storage rooms with combustible supplies are provided with a self-closing device mechanism.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what**	05/31/2023

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	lots and lots of combustible storage and supplies. The door to this room was not equipped with a self-closing device. b) The Clean utility Closet corridor door failed to self-close and latch. c) The door to the Women's Central Bath, being used as storage, failed to self-close and latch. Based on interview at the time of observation, the Maintenance Director agreed all three rooms were hazardous storage areas, and the doors to the rooms were not self-closing or did not latch into the frame. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**corrective action will be taken.** All residents have the potential to be affected but none were identified. The three doors listed 1.) medical records door upstairs, clean utility closet and door to women's central bath were all equipped with automatic self-closing mechanisms. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ED and maintenance director were reeducated on the deficient practice. Full audit of all rooms in the facility were observed and no other doors met criteria for self-closing mechanisms to be added. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will tour bldg monthly for 6 months to assure rooms that must need self-closing mechanisms are properly placed. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.	

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K 0324 SS=E 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 observation and interview, the facility failed to provide a kitchen hood extinguishing system which would provide complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice could affect all 5 staff. Findings include: Based on observations and interviews during a	K 0324	It is the responsibility of the facility to ensure that a kitchen hood extinguishing system provides complete coverage of equipment that produces grease-laden vapors. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what**	06/30/2023

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	tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the kitchen contained a grease hood over a 6 burner electric commercial range/oven combination. The kitchen staff was asked if they ever fry hamburgers and the like on the range under the hood and they stated yes. The commercial electric range was not covered by a suppression system. Based on interview at the time of observation, the Maintenance Director and Executive Director stated that a hood suppression system was not present. During records review no documentation of hood suppression inspections was available. Hood cleaning inspections from the vendor were available and current. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**corrective action will be taken.** All residents have the potential to be affected but none were identified. Estimates were received to install hood suppression system. All kitchen staff members and dietary manager were inserviced to not fry foods on range. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff were inserviced to not fry foods on the range until the hood suppression system is installed. A contractor will be installing the hood suppression system the week of June 26th. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The certified dietary manager and/or designee will ensure that no foods are fried on the stove top until hood suppression is installed. The monthly menu will be audited prior for scheduled menu items. Items will be removed and exchanged for substitution and approved by dietician. ED will oversee until hood installed.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 05/15/2 between 9:20 a.m. and 12:05 p.m., no documentation was provided regarding a visual semi-annual fire alarm system inspection. During the survey the Maintenance Director searched for the missing documentation but was unable to locate any further documentation.	K 0345	It is the responsibility of the facility to ensure that the fire alarm system in fully maintained and serviced. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. Contracted company Koorsen completed the visual semiannual fire alarm system inspection. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Contracted company Koorsen completed the visual semiannual fire alarm system inspection. **How the corrective action will be monitored to**	06/15/2023

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	This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will enter all completed contracted work into tels. monthly/quarterly and annual fire protection documentation will be brought to the monthly QAPI meeting for review. ED to oversee.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 05/15/2 between 9:20 a.m. and 12:05 p.m., the fire watch plan failed to include (1) contacting the	K 0346	**It is the policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. **How other residents having the potential to be affected by**	05/30/2023

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	Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Executive Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the IDOH Gateway link or at the e-mail address listed above. Additionally, (2) the fire watch plan failed to include language indicating that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. Based on interview at the time of record review, the Executive Director agreed the fire watch did not indicate that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential for being affected by the deficient practice, but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The fire alarm system-out of service policy has been revised on 5/30/23 to reflect that if the fire alarm system is out of service for more than four (4) hours in a 24-hour period who to contact (IDOH) and how to contact them. Verbiage has also been included in fire plan policy that the person conducting the fire watch will have to other duties while conducting the fire watch. **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?** The maintenance director or their designee will monitor monthly and as needed that if the fire alarm is out of service for more than four (4) hours in a 24-hour period that an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. ED will assure	

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			that policy is followed and IDOH is notified and care team member is on watch without any other duties. The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by	K 0353	It is the responsibility of the facility to ensure that the sprinkler system is inspected weekly including the control valves and gauges. **The corrective action taken for**	06/15/2023

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	155570	A. BUILDING 01 B. WING	05/15/2023

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	opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 05/15/2 between 9:20 a.m. and 12:05 p.m., the most recent inspection of internal piping was dated 02/12/18, more than 5 years ago. Based on interview at the time of record review, the Maintenance Director agreed the last internal inspection performed was more than 5 years. No other documentation was provided to show a more recent internal pipe inspection had been conducted. Additionally, no evidence of a more recent inspection was evident at the sprinkler riser location. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly		**those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. A weekly documentation was created and presented to Maintenance director. Maintenance Director was educated on tool to use to check control valves and gauges weekly. Documentation is to be uploaded into tels and hard copy kept with fire protection and LSC paperwork. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A weekly documentation was created and presented to Maintenance director. Maintenance Director was educated on tool to use to check control valves and gauges weekly. Documentation is to be uploaded into tels and hard copy kept with fire protection and LSC paperwork. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 05/15/2 between 9:20 a.m. and 12:05 p.m., no records were available indication the dry system control valves and gauges were inspected on a weekly bases. Based on interview at the time of record review, the Maintenance Director stated the valves are inspected weekly but the checks are not recorded. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3. Based on observation and interview, the facility failed to ensure sprinkler heads under the porch entrance canopy were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by		**assurance program will be put into place:** The maintenance director and/or designee will complete weekly sprinkler system inspection to check gauges and control valve weekly. Documentation will be brought to the monthly QAPI meeting for review. ED to oversee.	

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	the sprinkler manufacturer. This deficient practice could affect staff and up to 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., 1 of 2 sprinkler heads in Resident Room # 1 was covered in dust or showed signs of loading. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policy in the	K 0354	**It is the policy for the protection of residents**	05/30/2023

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	event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 05/15/2 between 9:20 a.m. and 12:05 p.m., the fire watch plan failed to include (1) contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Executive Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the IDOH Gateway link or at the e-mail address listed above. Additionally, (2) the fire		**indicating procedures to be followed in the event the automatic sprinkler system has to be placed out of service for ten hours or more in a 24 hour period.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential for being affected by the deficient practice, but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The automathc sprinkler system-out of service policy has been revised on 5/30/23 to reflect that if the automatic sprinkler system is out of service for more than four (10) hours in a 24-hour period who to contact (IDOH) and how to contact them. Verbiage has also been included in fire plan policy that the person conducting the fire watch will have to other duties while conducting the fire watch. **How the corrective action(s)**	

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	watch plan failed to include language indicating that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. Based on interview at the time of record review, the Executive Director agreed the fire watch did not indicate that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The maintenance director or their designee will monitor monthly and as needed that if the automatic sprinkler system is out of service for more than ten (10) hours in a 24-hour period that an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. ED will assure that policy is followed and IDOH is notified and care team member is on watch without any other duties. The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.	
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			

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	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 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.			
	1. Based on observation and interview, the facility failed to ensure 3 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 15 staff and residents. Findings include:	K 0363	**It is the policy for the protection of residents that the facility ensure all corridor doors have no impediment to closing and latching into the door frame and can resist the passage of smoke.** What corrective action(s) will be accomplished for those residents	06/30/2023

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	Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the following corridor doors failed to close and latch positively into the door frame. A) The upstairs social services office. B) The upstairs Storage Room door. C) Resident Room #17 Based on interview at the time of the observations, the Executive Director agreed the aforementioned corridor doors did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 4 staff. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the upstairs Storage Room door had a louver measuring approximately 15"X15" which would negate the ability of the door to be smoke tight. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the		found to have been affected by the deficient practice? No residents were affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential for being affected by the deficient practice, but none were. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The social service room door, storage room door and resident room #17 were all adjusted so that when closed they securely latched into the frame of the door. The upstairs storage door has been measured and door has been ordered to replace. All other doors were audited in the facility to ensure there was no impediments to latching into the door frame. No other doors were identified. **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?** The maintenance director or their designee will audit doors bi weekly x4 weeks weekly x4 weeks and monthly x4 months. All negative	

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	Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		findings will be immediately remedied and brought to the ED's attention The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure unsealed holes in 1 of 1 ceiling smoke barriers were protected to maintain the smoke resistance of the ceiling smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations	K 0372	**It is the policy for the protection of residents that the facility ensure there are no unsealed holes in the ceiling protecting the smoke resistance of the ceiling barrier.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by	06/15/2023

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	for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff at least 20 residents in the main long hallway. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., in the main long hallway, above the main Fire Alarm Control Panel, two speaker wires were penetrating the ceiling smoke barrier and were unsealed, leaving a gap of approximately ½" around the hole created by the wires. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential for being affected by the deficient practice, but none were. The holes from the speaker wire was filled with fire caulk. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The holes from the speaker wire was filled with fire caulk. A complete facility walk through was completed and no other penetrations were found. **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?** The maintenance director or their designee will do monthly audits x6 months. All negative findings will be immediately remedied and brought to the ED's attention The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. 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. This deficient practice could affect 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., when the GFCI electric receptacle in Resident Room #9 was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 2. Based on observation and interview, the facility	K 0511	It is the policy for the protection of residents that the facility ensure that GFCI outlets was properly maintained for protection against of electric shock. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The GFCI in resident room number 9 was replaced and is functioning correctly. All GFCI outlets were tested and work properly **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The GFCI in resident room number 9 was replaced and is functioning correctly. All GFCI outlets were	05/31/2023

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MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

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	failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the service hall. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 05/15/2 between 12:05 p.m. and 2:20 p.m., the electrical panel located on the ramp was unlocked when tested. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		tested and work properly **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?** The maintenance director or their designee will do monthly audits x6 months. All negative findings will be immediately remedied and brought to the ED's attention The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual	K 0761	It is the policy for the protection of residents that the facility ensure	06/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 01 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf		annual inspection and testing of all fire door assemblies. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Contractred company safe care came to do the annual inspection and testing of fire door assemblies. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Contractred company safe care came to do the annual inspection and testing of fire door assemblies. All deficiencies to be remedied by Safecare. **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?** The maintenance director and/or designee will enter all completed contracted work into tels. monthly/quarterly and annual fire protection documentation will be brought to the monthly QAPI	

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	155570	A. BUILDING 01 B. WING	05/15/2023

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	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. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 05/15/2 between 9:20 a.m. and 12:05 p.m., no documentation of an annual inspection of the facilities fire door assemblies was available for review. During the facility tour fire doors were observed in the long hall corridor and at the basement and second floor stairways. This finding was acknowledged by the Maintenance Director and Executive Director at the time of discovery and again by the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		meeting for review. ED to oversee.	