STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/11/2023	
	ROVIDER OR SUPPLIE		7476 W	ADDRESS, CITY, STATE, ZIP COD L'LANE RD RDSVILLE, IN 46055	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENC!)	DATE
K 0000 Bldg. 01	Recertification and conducted on 05/1 Indiana Department 42 CFR 483.90(a). Survey Date: 07/1 Facility Number: Provider Number: AIM Number: 100 At this PSR Life SC Care of McCordsv compliance with R Medicare/Medicai Life Safety from Foot National Fire Protectife Safety Code (Health Care Occup This two-story fact determined to be owns fully sprinkler system with smoke all areas open to the 22. The facility had detectors in 20 of 25 facility has a capace 32 at the time of the survey of the system with smoke all areas open to the 22. The facility had detectors in 20 of 25 facility has a capace 32 at the time of the survey of the system with smoke 32 at the time of the system with smoke 33 at the time of the system with smoke 34 at the time of the system with smoke 35 at the time of the system with smoke 36 at the time of the system with smoke 37 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the time of the system with smoke 38 at the system with smoke 38 at the system with smoke 39 at the system with smoke 30 at the system with smok	1/23 000477 155570 0290860 afety Code survey, Majestic ille was found not in tequirements for Participation in d, 42 CFR Subpart 483.90(a), fire, and the 2012 edition of the tection Association (NFPA) 101, LSC), Chapter 19, Existing pancies and 410 IAC 16.2. ility with a partial basement was aff Type V (000) construction and red. The facility has a fire alarm the detection in the corridors, in the corridor and in resident Room as battery operated smoke 21 resident sleeping rooms. The city of 48 and had a census of his PSR survey.	K 0000		
	unsprinklered, deta barn housing a spr tank and fire pump	ached 2 story wood frame pole inkler system water storage o; an unsprinklered, detached 2 r oxygen storage; and an			
LABORATOR Katlyn Coll		OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE HFA	TITLE	(X6) DATE 07/31/2023

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>0</u> 1	(X3) DATE SURVEY COMPLETED 07/11/2023	
	PROVIDER OR SUPPLIE		7476 V	ADDRESS, CITY, STATE, ZIP (V LANE RD RDSVILLE, IN 46055	COD
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE COMPLETION
TAG	unsprinklered, 2 ste housing a lawn mo blower.	R LSC IDENTIFYING INFORMATION ory wood barn used for wer and tractor and a snow mpleted on 07/17/23	TAG	DEFICIENCY	DATE
K 0161 SS=F Bldg. 01	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, un 19.1.6.2 through 19.1.6.4, 19.1.6.5	;			
		ction Type (332), II (222) Any number non-sprinklered and			
	2 II (111) non-sprinklered	One story			
	sprinklered	Maximum 3 stories			
	3 II (000) non-sprinklered	Not allowed			
	4 III (211) sprinklered 5 IV (2HH 6 V (111)	Maximum 2 stories			
	7 III (200) non-sprinklered 8 V (000) sprinklered Sprinklered storie	Not allowed Maximum 1 story s must be sprinklered			
	throughout by an	approved, supervised in accordance with section			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/11/2023 155570 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7476 W LANE RD MAJESTIC CARE OF MCCORDSVILLE MCCORDSVILLE. IN 46055 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0161 07/25/2023 It is the responsibility of the interview; the facility failed to ensure the building facility to ensure that the construction type for the two-story portion of the building construction type for facility was a permitted type as listed in Table the two-story portion of the 19.1.6.1. Table 19.1.6.1 prohibits a two story facility is permitted. sprinklered building to be of Type V(000) The corrective action taken for construction. This deficient practice could affect those residents found to be all residents, staff, and visitors. affected by the deficient practice includes: There are no Findings include: identified residents affected. How other residents that have Based on observations and interviews during a the potential to be affected by tour of the facility with the Maintenance Director the same defective practice and Executive Director on 07/11/23 between 1:25 will be identified and what p.m. and 3:00 p.m., the two-story portion of this corrective action will be taken. fully sprinklered building had exposed wood as All residents have the potential to the structural element for the exterior load bearing be affected but none were wall and an interior load bearing wall in the identified. An FSES evaluation sprinkler riser room in the basement. In addition, was conducted to ensure the the top portion of the stairwell wall in the attic had facility construction type is exposed wood with one half inch thick plaster permitted. covering the interior portion of the stairwell wall. What measures will be put into Residents have customary access to the dining place and what systemic room and the therapy room on the first floor of the changes will be made to two-story portion of the facility. Based on ensure that the deficient interview at the time of record review the practice does not recur: Executive Director stated this was part of the An FSES evaluation was FSES however, the requirements of the FSES of conducted to ensure the facility abandoning the second floor area and adding receives a passing score and the additional smoke detection in the basement have construction type is permitted. To not been completed. meet requirements, we have closed down the second floor. This finding was acknowledged by the Storage, offices and medical

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/11/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	the time of discover Maintenance Direct the exit conference.	or and Executive Director at cited on 05/15/23. The facility a systemic plan of correction		records have all been remove 7-25-23. see attachments Th smoke detectors were hard wi to our fire alarm system on 7-19-23. see attachments How the corrective action wi be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place: The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring QAPI monthly.	e red II ty ut	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on interview failed to maintain the basement area. If the Means of egress maintained to proview with other sections the headroom shall be mmm), with projection than 6 ft 8 in. (2030 in. (?19 mm), above otherwise specified	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0211	It is the responsibility of the facility to maintain the requir headroom space in the basement area. The corrective action taken f those residents found to be affected by the deficient practice includes: There are identified residents affected. How other residents that hav the potential to be affected b the same defective practice	no re	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 07/11/2023	
	PROVIDER OR SUPPLIER		7476 V	ADDRESS, CITY, STATE, ZIP COD W LANE RD DRDSVILLE, IN 46055	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	
TAG	less than 7 ft (2135 projections from the nominal above the findustrial equipment 40.2.5.2 shall be percould affect up to 5. Findings include: Based on observation tour of the facility wand Executive Director p.m. and 3:00 p.m., (2) Basement Storage below the required interview at the time Executive Director FSES however, the	mm) from the floor, with e ceiling not less than 6 ft 8 in. floor. (2) Headroom in at access areas as provided in rmitted. This deficient practice staff in the facility. ons and interviews during a with the Maintenance Director etor on 07/11/23 between 1:25 in (1) the Oil Furnace Room and ge area the ceiling height was minimum height. Based on e of record review the stated this was part of the requirements of the FSES of ond floor area and adding	TAG	will be identified and what corrective action will be tak All residents have the potenti be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. What measures will be put it 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 facil receives a passing score. To requirements, we have close down the second floor. Stora offices and medical records he	al to on nto ity meet d age,
K 0222	not been completed This finding was ac Maintenance Direct the time of discover Maintenance Direct the exit conference. This deficiency was	knowledged by the cor and Executive Director at ry and again by the cor and Executive Director at scited on 05/15/23. The facility a systemic plan of correction		all been removed as 7-25-23 attachments The smoke detectors were hard wired to fire alarm system on 7-19-23 attachments How the corrective action were be monitored to ensure the deficient practice will not recur, i.e., what quates assurance program will be printo place: The ED will assure that the second floor is abandoned ar remains out of use. We will continue to monitor and bring QAPI monthly.	our . see vill e lity out
SS=E Bldg. 01	Egress Doors Egress Doors	d means of egress shall not			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570			ILDING	nstruction 01	(X3) DATE COMPL 07/11 /	ETED	
NAME OF	PROVIDER OR SUPPLIEI	· }			DDRESS, CITY, STATE, ZIP COD		
					LANE RD		
MAJEST	TIC CARE OF MCC	UKUSVILLE		MCCOR	RDSVILLE, IN 46055		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	a latch or a lock that					
	1	of a tool or key from the					
	special locking an	s using one of the following					
		S OR SECURITY THREAT					
	LOCKING	ON OLOGICITY THINEAT					
		king arrangements for the					
	· ·	eeds of the patient are					
		cking device shall be					
	1	door and provisions shall					
	be made for the ra	apid 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.						
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
	· ·	king arrangements for the					
		e patient are used, all of curity Locking requirements					
		addition, the locks must be					
	1	at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
		er system and the locked					
	1	d by a complete smoke					
	1 .	(or is constantly monitored					
	at an attended loo	cation within the locked					
	space); and both	the sprinkler and detection					
	systems are arrar	nged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2						
	DELAYED-EGRE						
	ARRANGEMENT						
		delayed-egress locking					
	1 -	in accordance with					
		permitted on door					
	assemblies servir	ng low and ordinary hazard					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		· ′	ILDING	instruction 01	(X3) DATE COMPL 07/11 /	ETED		
		ROVIDER OR SUPPLIER			7476 W	ADDRESS, CITY, STATE, ZIP COD LANE RD RDSVILLE, IN 46055		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		an approved, super detection system of automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accordate permitted. 18.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exist accordance with 7 on door assemblied throughout by an automatic fire detection and automatic fire detection and open. 33.2.2.5. States a latch or other leaf shall be provided has an obvious method an obvious method and open. 33.2.3. States a latch or other leaf shall be provided has an obvious method an obvious method open and open. 33.2.1.5.10.4 states the states open the door leaf of the releasing operation. The releasing mechanism of less than 34 inclinitions, above the fire states and the states of the states	OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 7.2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an sed automatic sprinkler	K 02	222	It is the responsibility of the facility to ensure all exit door are provided with only one latching mechanism to releast the door and open. The corrective action taken for those residents found to be affected by the deficient practice includes: There are 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 take All residents have the potential be affected but none were identified. The deadbolt lock weremoved. Please see attachments.	no ne y n. I to	07/25/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/11/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	tour of the facility wand Executive Direct p.m. and 3:00 p.m., from the basement a latching devices, a rand a deadbolt latch requiring two operations one releasing operation. This finding was ac Maintenance Direct the time of discover Maintenance Direct the exit conference.	knowledged by the or and Executive Director at y and again by the or and Executive Director at cited on 05/15/23. The facility a systemic plan of correction		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The deadbolt lock was removed see attachment. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place: the maintenance director and/or designee will to bldg monthly for 6 months to assure all doors only have on latching mechanism to release door and open. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting\.	ill ity out our	
K 0225 SS=E Bldg. 01	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4, Based on observation failed to ensure 1 of was in accordance of requires a latch or of door leaf to be prove that has an obvious readily operated und	okeproof Enclosures okeproof enclosures used ordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility of 1 stairway enclosure door with 7.2. LSC Section 7.2.1.5.10 ther fastening device on a ided with a releasing device method of operation and is der all lighting conditions. ice affects 15 including staff	K 0225	It is the responsibility of the fato ensure that stairway enclosedoor is in ac The corrective action taken to those residents found to be affected by the deficient practice includes: There are identified residents How other residents that have the potential to be affected by	for no	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/11/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG K 0232 SS=F Bldg. 01	Findings include: Based on observation tour of the facility wand Executive Direct p.m. and 3:00 p.m., stairwell exit door wappeared to have be to latch. Additionally approximately a 4 in Executive Director opening door would rated door and hard force. This finding was ac Maintenance Direct the time of discover Maintenance Direct the exit conference. This deficiency was failed to implement to prevent recurrence. 3.1-19(b) NFPA 101 Aisle, Corridor, or Aisle, Corridor or Maintenance Direct the time of discover the exit conference.	ons and interviews during a with the Maintenance Director ctor on 07/11/23 between 1:25 the latch on the second floor was not functioning and en removed so the door failed by, there was now not hole in the door. The was informed that this vertical laneed to have the proper fire ware even with the FSES in knowledged by the or and Executive Director at y and again by the or and Executive Director at the cited on 05/15/23. The facility a systemic plan of correction ince. Ramp Width Ramp Width Ramp Width Roor corridors (clear or ving as exit access shall be maintained to provide the	TAG	the same defective practice will be identified and what corrective action will be take All residents have the potential be affected but none were identified. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: A door has been ordered but temporary waiver has been requested because of the time of delivery. Please see attack order form. How the corrective action was be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place: The maintenance director and designee will audit all doors monthly x6 months. All findin will be reported to the monthly QAPI meeting.	en. al to al eline ned iill dity ut d/or gs		
	on stretchers, exc 19.2.3.4, exceptio 19.2.3.4, 19.2.3.5	· ·	K 0232	It is the responsibility of the	07/26/2023		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
		155570	B. WI	ING		07/11/	/2023
NAME OF	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
NAA 1507		2000/414.5			LANE RD		
MAJEST	TIC CARE OF MCCO	DRDSVILLE		MCCOF	RDSVILLE, IN 46055		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to maintain th	ne required corridor width			facility to ensure that the		
	throughout the facil	lity. LSC 19.2.3.4* states any			building construction type fo	r	
	required aisle, corri	dor, or ramp shall be not less			the two-story portion of the		
	than 48 in. (1220 m	m) in clear width where serving			facility is permitted.		
	as a means of egres	s from patient sleeping rooms.			The corrective action taken f	or	
	This deficient pract	ice could affect all residents,			those residents found to be		
	staff, and visitors.				affected by the deficient		
					practice includes: There are	no	
	Findings:				identified residents affected.		
					How other residents that hav	'e	
	Based on observation	ons and interviews during a			the potential to be affected b	у	
	tour of the facility v	with the Maintenance Director			the same defective practice	-	
	and Executive Dire	ctor on 07/11/23 between 1:25			will be identified and what		
	p.m. and 3:00 p.m.,	the ramp and adjacent stairs			corrective action will be take	n.	
	measured 35 inches	s (ramp) and 33 inches (steps)			All residents have the potentia	l to	
	in width. The Main	tenance Director measured the			be affected but none were		
	widths of both the r	ramp and steps. Additionally,			identified. An FSES evaluation	1	
	the aforementioned	ramp which is approximately			was conducted to ensure we n	neet	
	15-20 feet in length	, did not appear to this			requirements.		
	surveyor to meet th	e overall slope requirement for			What measures will be put in	ito	
	existing facilities w	hich is 1 inch of fall for every 6			place and what systemic		
	inches of rise. Base	d on interview at the time of			changes will be made to		
	record review the E	xecutive Director stated this			ensure that the deficient		
		S however, the requirements of			practice does not recur:		
	the FSES of abando	oning the second floor area and			An FSES evaluation was		
	adding additional si	moke detection in the			conducted to ensure the facilit	у	
	basement have not	been completed.			receives a passing score and	the	
					construction type is permitted.	То	
	This finding was ac	knowledged by the			meet requirements, we have		
		tor and Executive Director at			closed down the second floor.		
	the time of discover				Storage, offices and medical		
		tor and Executive Director at			records have all been removed		
	the exit conference.				7-25-23. see attachments Th	е	
					smoke detectors were hard wi		
	1	s cited on 05/15/23. The facility			to our fire alarm system in the		
		a systemic plan of correction			basement on 7-19-23. see		
	to prevent recurrence	ce.			attachments. With these items	S	
					completed we are in complian	ce	

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2. Based on observation and interview, the facility

failed to keep all resident room corridors free from

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with our FSES score.

How the corrective action will

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	OF CORRECTION OF CORRECTION 155570	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/11/2023		
	PROVIDER OR SUPPLIER IC CARE OF MCCORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION DATE		
IAU	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. 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 07/11/23 between 1:25 p.m. and 3:00 p.m., The ramp in front of Resident Room 211 crossed in front of the resident's room and contained at least a 2 inch drop creating an unsafe condition for nonambulatory The Executive Directors office was now in this room. Based on interview at the time of record review the Executive Director stated this was part of the FSES however, the requirements of the FSES of abandoning the second-floor area and adding additional smoke detection in the basement have not been completed. 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. This deficiency was cited on 05/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	IAU	be monitored to ensure the deficient practi will not recur, i.e., what qu assurance program will be into place: The ED will assure that the second floor is abandoned a remains out of use. We will continue to monitor and brir QAPI monthly.	ce ality put		
K 0241 SS=E	NFPA 101 Number of Exits - Story and Compartment					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155570 B. WING 07/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7476 W LANE RD MAJESTIC CARE OF MCCORDSVILLE MCCORDSVILLE. IN 46055 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 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 The facility failed to provide the required number K 0241 It is the responsibility of the 07/25/2023 of exits from the basement area. LSC 19.2.4.4* facility to ensure that the states that Not less than two exits shall be building construction type for accessible from each smoke compartment, and the two-story portion of the egress shall be permitted through an adjacent facility is permitted and the compartment(s), provided that the two required amount of exits from the egress paths are arranged so that both do not basement area. pass through the same adjacent smoke The corrective action taken for compartment. This deficient practice could affect those residents found to be up to 5 staff in the facility. affected by the deficient practice includes: There are no Findings include: identified residents affected. How other residents that have Based on observations and interviews during a the potential to be affected by tour of the facility with the Maintenance Director the same defective practice and Executive Director on 07/11/23 between 1:25 will be identified and what p.m. and 3:00 p.m., in the basement only one corrective action will be taken. means of egress was provided. There appeared to All residents have the potential to be only one way into and one way out of the be affected but none were basement area. Based on interview at the time of identified. An FSES evaluation record review the Executive Director stated this was conducted to ensure the was part of the FSES however, the requirements of facility construction type is the FSES of abandoning the second-floor area and permitted. adding additional smoke detection in the What measures will be put into basement have not been completed. place and what systemic changes will be made to This finding was acknowledged by the ensure that the deficient Maintenance Director and Executive Director at practice does not recur: the time of discovery and again by the An FSES evaluation was Maintenance Director and Executive Director at conducted to ensure the facility the exit conference. receives a passing score and the

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155570	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/11/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
		s cited on 05/15/23. The facility a systemic plan of correction ce.		construction type is permitted meet requirements, we have closed down the second floor Storage, offices and medical records have all been remove 7-25-23. see attachments T smoke detectors in the baser were hard wired to our fire also system on 7-19-23. see attachments. With these corrections made we meet compliance for our FSES sur How the corrective action where the deficient practic will not recur, i.e., what qual assurance program will be printo place: The ED will assure that the second floor is abandoned ar remains out of use. We will continue to monitor and bring QAPI monthly.	ed as he nent arm vey. iiii e lity out	
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on interview determined that the exterior emergency Section 7.9.1.1 required facilities for means the exit access and practice could affect including staff, visi	ng g of at least 1-1/2-hour ed automatically in	K 0291	It is the responsibility of the facility to ensure that the exterior emergency lighting all exits are equipped to wo during power failure. Exterioxit lighting will be hooked generator. The corrective action taken those residents found to be	for rk for to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/11/2023 155570 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7476 W LANE RD MAJESTIC CARE OF MCCORDSVILLE MCCORDSVILLE. IN 46055 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and the generator was providing electricity at that affected by the deficient time. This deficient practice could affect everyone practice includes: There are no in the facility. identified residents Findings include: How other residents that have the potential to be affected by Based on observations and interviews during the same defective practice records review and a tour of the facility with the will be identified and what Maintenance Director and Executive Director on corrective action will be taken. 07/11/23 between 1:25 p.m. and 3:00 p.m. it was All residents have the potential to unknown if the exterior lights for the exit be affected but none were discharge for all of the facility exits were identified. The exterior emergency connected to the generator. The Maintenance lighting was hooked to generator Director and the Executive Director stated that in case of power failure on they had been told by their contractor that the exit 7/24/23. lights were connected to the generator, but no What measures will be put into documentation was provided to verify the place and what systemic facilities exit lighting were connected to the changes will be made to generator and could illuminate in the event of a ensure that the deficient power outage. practice does not recur: The exterior emergency lighting This finding was acknowledged by the was hooked to generator in case Maintenance Director and Executive Director at of power failure on 7/24/23 by the time of discovery and again by the safecare. Maintenance Director and Executive Director at How the corrective action will the exit conference. be monitored to ensure the deficient practice This deficiency was cited on 05/15/23. The facility will not recur, i.e., what quality failed to implement a systemic plan of correction assurance program will be put to prevent recurrence. into place: The maintenance director and/or 3.1-19(b) 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.

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 155570 NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF MCCORDSVILLE (X4) ID PRIEFIX (RACH DEPICIENCY MUST BE PRECEDED BY PLLL TAG REGULATORY OR IS DENTIFYING INFORMATION K 0345 NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with 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 National Fire Alarm systems in accordance with strapections 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 tuels 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 impacted semi-annually: a. Control unit trouble signals b. Remote amunicators c. Initiating devices (e.g., duet detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on observations and interviews during records seview and a tour of the facility with the Maintenance Director and Executive Director on 07/12/23 between 125 pm. and 3.00 pm., no 07/12/23 between 125 pm. and 3.00 pm.,	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
MAJESTIC CARE OF MCCORDSVILLE MAJESTIC CARE OF MCCORDSVILLE SITREET ADDRESS. CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055 MCCORDSVILL	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
MAJESTIC CARE OF MCCORDSVILLE MAJESTIC CARE OF MCCORDSVILLE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGULATORY OR LISC IDENTIFYING INFORMATION RAGUAL TORY OR LISC IDENTIFYING INFORMATION A fire alarm system - Testing and Maintenance Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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. 9.6.13, 9.6.15, 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 utless 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 annuacitors c. Initiating devices (e.g., duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances c. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: HAVE WARK TO MCCROSVILLE, IN 46055 (X3) D. REFIX TAO OF COMPLETOR STATEMENT O			155570	B. W	ING		07/11/	/2023
MAJESTIC CARE OF MCCORDSVILLE MAJESTIC CARE OF MCCORDSVILLE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGULATORY OR LISC IDENTIFYING INFORMATION RAGUAL TORY OR LISC IDENTIFYING INFORMATION A fire alarm system - Testing and Maintenance Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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. 9.6.13, 9.6.15, 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 utless 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 annuacitors c. Initiating devices (e.g., duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances c. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: HAVE WARK TO MCCROSVILLE, IN 46055 (X3) D. REFIX TAO OF COMPLETOR STATEMENT O					STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
MAJESTIC CARE OF MCCORDSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENTE TAG REGULATORY OR LSC IDENTIFYING INFORMATION K 0345 NFPA 101 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 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 schedules in Table 14.3.1, or more often if required by the suthority 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-pene devices This deficient practice could affect all building occupants. Findings include: Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on	NAME OF P	PROVIDER OR SUPPLIER						
REGILATORY OR LSC IDENTIFYING INFORMATION K 0345 SS=F 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 isopections 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 state that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (c.g., duet 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 observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on	MAJESTI	IC CARE OF MCCC	DRDSVILLE					
K 0345 SS=F Bldg. 01 Fire Alarm System - Testing and Maintenance 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 observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
K 0345 SS=F Bldg. 01 Fire Alarm System - Testing and Maintenance 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 observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
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 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 a 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. Imitating 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. Eindings include: Have 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. Contracted company Korsen completed the visual seminanual fire alarm system inspection on 7-12-23 please see attached What measures will be put into place and what systemic changes will be made to ensure that the deficient			LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bidg. 01 Maintenance 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 77, 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., duet 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 observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on								
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inspection on 7-12-23 please see attached What measures will be put into Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on inspection on 7-12-23 please see attached What measures will be put into place and what systemic changes will be made to ensure that the deficient		-	ice could affect all building					
Findings include: Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on attached What measures will be put into place and what systemic changes will be made to ensure that the deficient		occupants.				1		
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Based on observations and interviews during records review and a tour of the facility with the Maintenance Director and Executive Director on place and what systemic changes will be made to ensure that the deficient		r manigs include:					nto.	
records review and a tour of the facility with the Maintenance Director and Executive Director on Changes will be made to ensure that the deficient		Rased on observation	one and interviews during			-	ito	
Maintenance Director and Executive Director on ensure that the deficient			_			1 -		
			-			_		
TATELLES VOLVOUR LASS DAILS AND DAILS NO TO THE TRANSPORT OF THE						practice does not recur:		
documentation was provided regarding a visual Contracted company Koorsen						=		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/11/2023	
	ROVIDER OR SUPPLIER		7476 V	ADDRESS, CITY, STATE, ZIP COD V LANE RD RDSVILLE, IN 46055	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	semi-annual fire ala the survey, the Main to the vendor for the was unable to locate This finding was ac Maintenance Direct the time of discover Maintenance Direct the exit conference. This deficiency was failed to implement to prevent recurrence 3.1-19(b) NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8,	rm system inspection. During intenance Director reached out a missing documentation but any further documentation. knowledged by the or and Executive Director at any and again by the or and Executive Director at any and again by the or and Executive Director at a systemic plan of correction as a systemic plan of correction as a systemic plan of correction are. Maintenance and Testing and Maintenance and Testing are and standpipe systems and ted, and maintained in a system. Mere A 25, Standard for the angular protection Systems. In design, maintenance, and readily available. System last checked and readily available. System test supply source RKS information on non-required or partial ar system.	K 0353	completed the visual semiann fire alarm system inspection of 7-12-23 please see attached. How the corrective action where the deficient practice will not recur, i.e., what qual assurance program will be printo place: The maintenance director and designee will enter all comple contracted work into tels. monthly/quarterly and annual protection documentation will brought to the monthly QAPI meeting for review. ED to oversee.	ill ity ut d/or ted fire be
i		· ,J	12 0333		01/13/2023

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488V22

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155570	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/11/2023		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF MCCORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055				
	SUMMARY: (EACH DEFICIEN REGULATORY OR failed to maintain 1 accordance with 19 14.2.1 states except 14.2.1.4 an inspecti conditions shall be opening a flushing of main and by remove of one branch line of for the presence of material. This defic occupants. Findings include: Based on observation records review and Maintenance Direct of 17/11/23 between 1 recent inspection of 02/12/18, more than interview at the time Maintenance Direct inspection performs other documentation more recent internal conducted. This finding was ac Maintenance Direct the time of discovery or service of the service of th	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION of 1 sprinkler system in 3.5.3. NFPA 25, 2011 Edition, as discussed in 14.2.1.1 and on of piping and branch line conducted every 5 years by connection at the end of one ing a sprinkler toward the end for the purpose of inspecting foreign organic and inorganic ient practice could affect all ons and interviews during a tour of the facility with the or and Executive Director on 25 p.m. and 3:00 p.m., the most internal piping was dated a 5 years ago. Based on e of record review, the or agreed the last internal ad was more than 5 years. No an was provided to show a I pipe inspection had been knowledged by the or and Executive Director at ry and again by the or and Executive Director at			en. al to hy hal see ill dity ut d/or ted fire		
		s cited on 05/15/23. The facility a systemic plan of correction ee.		meeting for review. ED to oversee.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155570		A. BU	A. BUILDING <u>01</u> B. WING		COMPLETED 07/11/2023		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF MCCORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 7476 W LANE RD MCCORDSVILLE, IN 46055				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
		corridor openings in other					
	T =	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	-	g fire for at least 20 fully sprinklered smoke					
		only required to resist the					
	-	. Corridor doors and doors					
	to rooms containing						
		rials have positive latching					
		atches are prohibited by					
		hese requirements do not					
	-	spaces that do not contain					
	flammable or com	-					
		n bottom of door and floor					
		ceeding 1 inch. Powered					
	_	vith 7.2.1.9 are permissible					
		device capable of keeping					
	the door closed wh	nen a force of 5 lbf is					
	applied. There is no impediment to						
	closing of the door	rs. Hold open devices that					
	release when the	door is pushed or pulled are					
	permitted. Nonrate	ed protective plates of					
	_	e permitted. Dutch doors					
		are permitted. Door					
	frames shall be lat	peled and made of steel or					
		compliance with 8.3,					
	unless the smoke						
	•	fire window assemblies are					
		sprinklered compartments					
		ctions in area or fire					
	resistance of glass assemblies.	s or frames in window					
	19.3.6.3, 42 CFR I 483, and 485	Parts 403, 418, 460, 482,					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
155570		B. W	B. WING 07/11/2023			/2023	
NAME OF PROJUDER OR GUIRN JER			-	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				7476 W	/ LANE RD		
MAJESTIC CARE OF MCCORDSVILLE				MCCO	RDSVILLE, IN 46055		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		S details of doors such as					
		ngs, automatics closing					
	devices, etc.						
		on and interview, the facility			It is the responsibility of the		07/25/2023
		f over 30 corridor doors had no			facility to ensure cooridors		
	_	ing and latching into the door			have no impediment to closi	ng	
		sist the passage of smoke.			and latching into the door		
	-	ice could affect 15 staff and			frame.	,	
	residents.				The corrective action taken f	or	
	Eludia 1 1 1				those residents found to be		
	Findings include:				affected by the deficient		
	D	1 :4 4			practice includes: There are	no	
	Based on observations and interviews during				identified residents affected.		
	records review and a tour of the facility with the				How other residents that have	-	
	Maintenance Director and Executive Director on				the potential to be affected b	У	
	07/11/23 between 1:25 p.m. and 3:00 p.m., the				the same defective practice will be identified and what		
	corridor door failed to close and latch positively					_	
	into the door frame in the upstairs Storage Room. Additionally, the aforementioned door had				corrective action will be take All residents have the potentia		
	-				be affected but none were	11 10	
	louvers and was not smoke tight. Based on interview at the time of record review the				identified. An FSES evaluation	,	
	Executive Director stated this was part of the				was conducted to ensure the	1	
	FSES however, the requirements of the FSES of				facility construction type is		
	abandoning the second-floor area and adding				permitted.		
	additional smoke detection in the basement have				What measures will be put in	ito	
	not been completed.				place and what systemic		
	not open completed.				changes will be made to		
	This finding was acknowledged by the				ensure that the deficient		
	Maintenance Director and Executive Director at				practice does not recur:		
	the time of discover	ry and again by the			An FSES evaluation was		
	Maintenance Director and Executive Director at		1		conducted to ensure the facility		
	the exit conference.				receives a passing score. To meet		
					requirements, we have closed		
	This deficiency was cited on 05/15/23. The facility				down the second floor. Storag		
	failed to implement	a systemic plan of correction		offices and medical red		ave	
	to prevent recurrence	ce.			all been removed as 7-25-23.	see	
					attachments The smoke		
	3.1-19(b)				detectors were hard wired to o	our	
					fire alarm system on 7-19-23.	see	
		1		attachments With this comple			

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ENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED
	155570	B. WING	07/11/2023

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7476 W LANE RD MAJESTIC CARE OF MCCORDSVILLE MCCORDSVILLE, IN 46055 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE we meet standards and pass FSES criteria. 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 ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to

QAPI monthly.

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