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

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618			JILDING	ONSTRUCTION	(X3) DATE COMPI 06/13	LETED
	PROVIDER OR SUPPLIE			12999 1	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
IVIAJES I	TO CARE OF CARI	/IEL		CARIVIE	EL, IN 40032		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg	conducted by the Ir accordance with 42  Survey Date: 06/13  Facility Number: 0  Provider Number: 200  At this Emergency Care of Carmel was compliance with En Requirements for N Participating Provid 483.73.  The facility has 104 the survey, the cens	2001149 155618 1145500  Preparedness survey, Majestic is found in substantial mergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR  4 certified beds. At the time of sus was 58.  Inducted on 06/14/23	E 0	000	E000 The creation and submission the Plan of Correction does constitute an admission by the provider of any conclusion in the statement of deficient of any violation or regulation provider respectfully request 2567 Plan of Correction be letter of credible allegation at REQUESTS A DESK REVIELIEU OF A POST SURVEY REVISIT on or after 8/01/20 Despite the citations the EP survey states:  At this Emergency Prepared survey, Majestic Care of Cawas found in substantial compliance with Emergency Preparedness Requirement Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. 1 In.9-13	not his let forth sies or h. This ts the the and EW IN  23. P  dness rmel r s for	
SS=C Bldg		Sharing Plan with Patients					
	maintain an emer communication pl Federal, State and reviewed and upd	es at §483.73(c):] ity must develop and gency preparedness an that complies with d local laws and must be lated at least annually. The an must include all of the					
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	 Е	TITLE		(X6) DATE

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

(X6) DATE

John Seib **Executive Director** 06/29/2023

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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i f		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155618	B. W	ING		06/13/	2023
	PROVIDER OR SUPPLIER		•	12999 N	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE COMPENSA DE LOS COMPENSAS DE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	emergency prepare plan that complies local laws and mu at least every 2 ye plan must include  (8) A method for semergency plan, to determined is approclients] and their forms and their forms are from the emergency determined is approclients or represent CFR 483.75(c)(8). The following include:  Based on records respectively affect all occupants  Findings include:  Based on records respective Director on 06/13/23 between Executive Director on 06/13/23 between Emergency Prepare address a method for contained within the deems appropriate to representatives. Based records review, the this requirement is a paper with the necessal and had not be deadless.	aust develop and maintain an redness communication with Federal, State and set be reviewed and updated ears. The communication all of the following:]  Sharing information from the chat the facility has propriate, with residents [or samilies or representatives. Wiew and interview, the facility emergency preparedness plan ethod for sharing information with plan that the facility has priate with residents and their statives in accordance with 42. This deficient practice could defined and the Maintenance Director on 8:45 a.m. and 12:05 p.m., the edness Binder provided did not for sharing information to be EPP Binder that the facility with clients, their families, or sed on interview at the time of Executive Director stated that met by providing a sheet of sarry information upon the facility had run out of been distributing the required by and they did not have a copy	E 00	035	E035 LTC and ICF/IID SHARII PLAN WITH PATIENTS Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance 42CFR 483.75(c)(8). This deficient practice could affect a occupants. Findings include: Based on records review and interview with the Executive Director and the Maintenance Director on 06/13/23 between 8:45a.m. and 12:05 p.m., the Emergency Preparedness bind provided did not address a met for sharing information contain within the EPP binder that the facility deems appropriate with clients, their families or	with all der thod	08/01/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155618	B. WING		06/13/2023	
NAME OF F	DROVIDED OD GUDDI IEI		STREET	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEI		12999	N PENNSYLVANIA ST		
MAJEST	IC CARE OF CAR	ΛEL	CARMI	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	This finding was ac	knowledged by the Executive		representatives. Based on		
	Director and the M	aintenance Director at the time		interview at the time of record	s	
	of records review a	nd again at the exit conference		review, the Executive Director		
	with the Executive	Director, Maintenance Director,		stated that this requirement is	met	
	and Assistant Main	tenance personnel present.		by providing a sheet of paper	with	
				the necessary information upo	on	
				admission, however the facilit	y	
				had run out of copies and had	not	
				been distributing the required		
				information recently and they	did	
				not have a copy for review.		
				What corrective action(s) will	I	
				be accomplished for those		
				residents found to have been	n	
				affected by this practice?		
				· The Executive Director a		
				or designee notified all clients	,	
				their families and / or their		
				representatives of the location	of a	
				copy of the Emergency		
				Preparedness Plan (EPP) whi	<b>I</b>	
				available for review via(1) Flye		
				Posting at the AL front entry;		
				(3) Posting at the SNF Ambula		
				entrance. An addendum has b	peen	
				added to the facility welcome		
				packet to further inform new		
				residents on or before 8/01/20	)23.	
				How will you identify all other	er	
				residents having the potential	al	
				to be affected by the same		
				deficient practice and what		
				corrective action will be take	en?	
				· All residents, visitors, ar	nd	
				staff have the potential to be		
				affected by the alleged deficie	nt	
				practice.		
				The Executive Director a	and	

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or designee notified all clients,

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION _ <del></del>	COMF	E SURVEY PLETED 3/2023
	ROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP C N PENNSYLVANIA ST EL, IN 46032	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				their families and / or the representatives of the copy of the Emergency Preparedness Plan (El available for review via Posting at the AL front (3) Posting at the SNF entrance. An addenduradded to the facility we packet to further informates along with the regarding the same on 8/01/2023.  What measures will be place or what system changes you will make ensure the deficient point will not recur?  The Executive Dieron or designee notified all their families and / or the copy of the Emergency Preparedness Plan (El available for review via Posting at the AL front (3) Posting at the AL front (3) Posting at the SNF entrance. An addenduradded to the facility we packet to further informates along with the regarding the same on 8/01/2023.  How will the corrective action(s) be monitore ensure the deficient point or the cour?  The Executive Dieron of the Executive Dieron of the Executive Dieron of the copy of the same on 8/01/2023.	location of a y PP) which is a(1) Flyer; (2) entry; and Ambulance um has been elcome in new is posting in or before  e put into ic to to practice irrector and it clients, heir location of a y PP) which is a (1) Flyer; (2) entry; and Ambulance in new is elecome in new is posting in or before  e posting in or before	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155618			A. BUILDING  B. WING		COMPLETED 06/13/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				or designee notified all clients, their families and / or their representatives of the location copy of the Emergency Preparedness Plan (EPP) whi available for review via (1) Fly. Posting at the AL front entry; a (3) Posting at the SNF Ambula entrance An addendum has be added to the facility welcome packet to further inform new residents along with the posting regarding the same on or beformation and report to the Continuous Quality Improvement Committee on their results from the inspections.  The Maintenance Direct and Administrator are responsifor these results.	of a ch is er; (2) and ance been  ng ore  vill ents m		
K 0000							
Bldg. 01	Licensure Survey w Department of Healt 483.90(a).  Survey Date: 06/13  Facility Number: 06  Provider Number: 10  AIM Number: 2001  At this Life Safety C	01149 155618	K 0000	E000 The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation or regulation. provider respectfully requests 2567 Plan of Correction be the letter of credible allegation and REQUESTS A DESK REVIEW LIEU OF A POST SURVEY REVISIT on or after 8/01/2023	ot s s forth s or This the e d / IN		

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	PROVIDER OR SUPPLIER		12999 N	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(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 APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0222 SS=F Bldg. 01	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of the Interest of the I	the 2012 edition of the edition Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2.  The alarm system with smoke editors, spaces open to the exidors, spaces open to the exidors, spaces open to the exidors, the alarm system with smoke editors, spaces open to the exidors, spaces open to t		Despite the citations the EPP survey states: At this Emergency Preparednessurvey, Majestic Care of Carm was found in substantial compliance with Emergency Preparedness Requirements f Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. Part 1 In.9-13	or	
	requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security nesused, only one lock permitted on each be made for the raby: remote control locks or keys carri	a latch or a lock that f a tool or key from the s using one of the following angements: G OR SECURITY THREAT  king arrangements for the eds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155618	A. BUILDING B. WING	01	COMPLETED 06/13/2023
		100010	D. WING		00/13/2023
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST	
MAJEST	IC CARE OF CARM	ΛEL		EL, IN 46032	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	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				
	ARRANGEMENT				
		king arrangements for the			
	-	e patient are used, all of			
		curity Locking requirements			
	-	addition, the locks must be			
		at fail safely so as to			
	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked				
		d by a complete smoke			
	-	(or is constantly monitored			
		cation within the locked			
		the sprinkler and detection			
	upon activation.	nged to unlock the doors			
	18.2.2.2.5.2, 19.2	2252 TIA 124			
	DELAYED-EGRE				
	ARRANGEMENT				
	_	delayed-egress locking			
		in accordance with			
	-	permitted on door			
		ng low and ordinary hazard			
		ngs protected throughout by			
		ervised automatic fire			
		or an approved, supervised			
	automatic sprinkle				
	18.2.2.2.4, 19.2.2				
		ROLLED EGRESS			
	LOCKING ARRAN				
		d Egress Door assemblies			
		dance with 7.2.1.6.2 shall			
	be permitted.	-			
	18.2.2.2.4, 19.2.2	.2.4			
	· ·	BY EXIT ACCESS			
	LOCKING ARRANGEMENTS				

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Elevator lobby exit access door locking in

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	PROVIDER OR SUPPLIER		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ED BY FULL PREFIX PREFIX CACHO TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	accordance with 7	7.2.1.6.3 shall be permitted			
		es in buildings protected			
		approved, supervised			
		ection system and an			
	1	sed automatic sprinkler			
	system.				
	18.2.2.2.4, 19.2.2				00/04/0000
		ation and interview, the facility	K 0222	K 222 EGRESS DOORS	08/01/2023
		f 3 delayed egress locking installed in accordance with		This requirement is not met as	
		hich states an irreversible		evidenced by:  1. Based on observation and	d
	` '			interview, the facility failed to	u
	process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where			ensure 3 of 3 delayed egress	
	approved by the authority having jurisdiction,			locking arrangements were	
		a force to the release device		installed in accordance with LS	ıc.
		10 under all of the following		7.2.1.6(3) which states an	
	conditions:	i o unuer un er me rene ming		irreversible process shall release	se
		not be required to exceed 15 lbf		the lock in the direction of egre	l l
	(67 N).	•		within 15 seconds, or 30 secon	
	. ,	not be required to be		where approved by the authorit	
	continuously applie	ed for more than 3 seconds.		having jurisdiction, upon	
	(c) The initiation of	the release process shall		application of the force to the	
	activate an audible	signal in the vicinity of the		release device required in	
	door opening.			7.2.1.5.10 under all of the follow	wing
	` '	as been released by the		condition:	
		to the releasing device,		(a) The force shall not be	
		y manual means only. This		required to exceed 15lbf (67N).	
	deficient practice co	ould affect 22 residents.		(b) The force shall not be	
				required to be continuously	
	Findings include:			applied for more than 3 second	
	Donad or share d	on and interview with the		(c) The initiation of the releas	
		and the Maintenance Director		process shall activate an audib	
		a facility tour between 12:05		signal in the vicinity of the door	
	_	the following exit doors were		opening. (d) Once the lock has been	
		second delayed egress. When		released by the application of	
		tested the irreversible process		force to the releasing device,	
		was not initiated or took		relocking shall be by manual	
	excessive pressure			means only	
	_	rs into the service hall		Findings include:	

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 06/13/2023 155618 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12999 N PENNSYLVANIA ST MAJESTIC CARE OF CARMEL CARMEL. IN 46032 (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 corridor, delayed egress did not function. Based on observation and B) Door #1 exit door near the generator took interview with the Executive excessive pressure to pull and did not function. Director and Maintenance Director Additionally, the provided signage stated the on 6/13/23 during a facility tour ... door should be pushed to activate the delayed the following exit doors were egress when in fact the door needs to be pulled. equipped with a 15 second C) Several other exit doors equipped with delayed delayed egress. When the exit egress signage took excessive pressure to doors were tested the irreversible activate the process. The Maintenance Director process to release the lock was stated the mechanisms would need to be adjusted. not initiated or took excessive pressure to release the door. This finding was acknowledged by the Executive (A) The double doors into the Director and the Maintenance Director at the time service hall corridor, the delayed of discovery and again at the exit conference with egress did not function. the Executive Director, Maintenance Director, and (B) Door #1 exit door near the Assistant Maintenance personnel present. generator took excessive pressure to pull and did not function. 2. Based on observation and interview, the facility Additionally, the provided signage failed to ensure all exterior exit doors were readily stated the door should be pushed accessible and able to open on first try. This to activate the delayed egress deficient practice could affect all occupants in the when in fact the door needs to be facility. pulled. (C) Several other exit doors Findings include: equipped with delayed egress signage took excessive pressure Based on observation and interview with the to activate the process. The Executive Director and the Maintenance Director Maintenance Director stated the on 06/13/23 during a facility tour between 12:05 mechanisms would need to be p.m. and 1:45 p.m., the exit door to the north, adjusted. facing the neighboring pool, would not open Based on observation and easily on the first try when tested. The Surveyor, interview, the facility failed to then the Maintenance Director tried to open the ensure all exterior exit doors were door. Then, the Executive Director kicked the door readily accessible and able to and was able to open the stuck door after open on first try... considerable effort. The Maintenance Director stated that during COVID they had used this door Findings include: extensively but not much recently. Based on observation and This finding was acknowledged by the Executive interview with the Executive

Director and the Maintenance Director at the time

Director and Maintenance Director

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155618	B. W	ING		06/13/	/2023	
N. M. O. T.	DROLUBER OF STREET	n.		STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF 1	PROVIDER OR SUPPLIE	K		129991	N PENNSYLVANIA ST			
MAJEST	IC CARE OF CAR	MEL		CARME	EL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		gain at the exit conference with			on 6/13/23 during a facility tou			
		ctor, Maintenance Director, and			the exit door to the north, facil	-		
	Assistant Maintena	ance personnel present.			the neighborhood pool, would			
	2.1.10(b)				open easily on the first try who			
	3.1-19(b)				tested. The surveyor, then the			
					maintenance director tried to			
					the door. Then the Executive			
					Director kicked the door and was able to open the stuck door at			
					considerable effort.	lei		
					What corrective action(s) wi	II.		
					be accomplished for those	•		
					residents found to have bee	n		
					affected by this practice?			
					The Maintenance Direct	or		
					contacted SAFECARE to add			
					issues with the Delayed egres			
					functions with the identified do			
					to ensure that the delayed eg			
					was functioning properly.			
					Specifically Safecare address	ed		
					identified issues with the doub	ole		
					doors into the service hall cor	ridor;		
					Door #1; and reviewed all oth	er		
					doors equipped with delayed			
					egress to ensure that the dela	-		
					egress activated without exce			
					pressure and functioned prop	•		
					· The signage posted at o	loor		
					#1 was modified to reflect the	•		
					need to pull the door instead			
					pushing it to activate the delay	yea		
					egress.	·or		
					The Maintenance Direct			
					performed maintenance on the	e exit		
					door to the north, facing the	that it		
					neighborhood pool to ensure opens easily and is readily	แเสเ เเ		
					accessible on the first try with	out		
					use of excessive pressure	out		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/13/2023
	ROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIE	TSTATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	ALGOLATORI C	THE DESTRUCTION OF THE PROPERTY OF THE PROPERT		regress doors to ensure that egress doors to ensure that egress doors in the facility of easily and are readily access and are equipped with accusignage.  How will you identify all of residents having the potent to be affected by the same deficient practice and what corrective action will be tare. All residents, visitors, staff have for egress have the potential to be affected by the alleged deficient practice.  The Maintenance Directory performed an inspection of egress doors to ensure that remaining egress doors in the facility open easily and are accessible with accurate significant process. The Maintenance Directory of all egress doors ensure that all remaining egress systems in the facility functioning properly.  What measures will be put place or what systemic	ector all call open ssible trate  ther ntial call dector and he he ector all call he readily gnage. ector  rs to gress d d ty are
				changes you will make to ensure the deficient practi will not recur?  The Maintenance Dire will monitor the egress door weekly for four weeks and a	ector 's

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	T OF DEFICIENCIES  DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 3/2023
	ROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP CO N PENNSYLVANIA ST EL, IN 46032	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
				monthly thereafter as a task added to the TELS ensure that all egress defacility open easily and a accessible and are equivaccurate signage.  The Maintenance will monitor the egress of equipped with delayed esystems weekly for four and at least monthly the a required task added to system to ensure that all doors with delayed egresystems are functioning.  How will the corrective action(s) be monitored ensure the deficient provided ensure the deficient p	system to cors in the care readily pped with  Director doors egress weeks creafter as to the TELS ill egress ess properly.  to actice  complete a col daily for seven cer to ill aintained rers. If it achieved eveloped to executive care so will be will be via esignee	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		<b>1</b> ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01		(X3) DATE SURVEY COMPLETED		
		155618	B. WING 06/13/2023				/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
K 0281 SS=E Bldg. 01	discharge, is arrar and shall be either or capable of auto manual intervention 18.2.8, 19.2.8  Based on observation failed to ensure con of 2 exits. For the prexit access shall incompassageways leading of this requirement, only designated states escalators, walkway leading to a public would affect up to 15.  Finding include:  Based on observation Executive Directors on 06/13/23 during p.m. and 1:45 p.m.,	ans of Egress ans of egress, including exit aged in accordance with 7.8 r continuously in operation matic operation without on.  on and interview, the facility tinuity of egress lighting for 2 ourposes of this requirement, lude only designated stairs, aps, escalators, and g to an exit. For the purposes exit discharge shall include rs, aisles, corridors, ramps, rs and exit passageways way. This deficient practice	K 028	31	Safety Committee at their more meetings.  The Safety Committee was monitor results of the inspection and report to the Continuous Quality Improvements Commit on their results from the inspections.  The Maintenance Direct and Administrator are responsifor these results.  K 281 ILLUMINATION OF MEANS OF EGRESS  Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 2 exits. For the purposes of this requirement eacess shall include only designated stairs, aisle, corridor ramps, escalators, and passageways leading to an exfort the purposes of this requirement, exit discharge shinclude only designated stairs aisles, corridors, ramps, escalators, walkways and exit passages leading to the public way. Findings include:	vill ons ttee or sible e exit lors, kit. hall	08/01/2023

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED		
		155618	B. W	ING		06/13/2023		
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
NAA IEGE		AE1			N PENNSYLVANIA ST			
WAJEST	IC CARE OF CARM	/IEL		CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тс	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	remain on powered	by the generator in the event			Based on observation and			
	_	The provided light had a			interview with the Executive			
		tested turned off the light			Director and the Maintenance			
		t access. Based on interview at			director on 6/13/23 during a fa			
	_	tions, the Maintenance			tour the (1) exit access in "tl	-		
		there were no other lighting			tube" did not have egress light			
		g this exit access passageway.			which would remain on power	_		
		e light in the North Stair Tower			by the generator in the event of			
		oright enough to provide			emergency. The provided ligh			
		well. The Maintenance Director			had a switch, which when test			
		some bulbs were burned out			turned off the light illuminating			
		t in the stair tower would need			exit access. Based on an	uio		
		ows or other lighting source			interview at the time of			
		aforementioned stair tower.			observations, the maintenance	۵		
	Were visione in the c	arorementioned stain to wer.			director confirmed there were			
	This finding was ac	knowledged by the Executive			other lighting devices illuminate			
	_	aintenance Director at the time			the exit access passageway.	uiig		
		ain at the exit conference with			Additionally, (2) the light in the	,		
		etor, Maintenance Director, and			North stair tower did not illumi			
		nce personnel present.			bright enough to provide lighting			
	7 issistant mantena	nee personner present.			the stairwell. The Maintenance	-		
	3.1-19(b)				Director stated that some bulb			
	3.1 17(0)				were burned out and the ceilir			
					light in the stair tower would n	_		
					attention.	ccu		
					What corrective action(s) wil			
						•		
					be accomplished for those residents found to have been	,		
					affected by this practice?	•		
					The Maintenance Direct	or		
					had an electrician modify the l	-		
					so that it was not turned on ar			
					by a switch and ensured that t			
					light would remain on and pov			
					by the generator in the event	oi an		
					emergency.			
					The Maintenance Direct			
					replaced the lights in the North			
					Stair Tower to ensure that the			
					stairwell is illuminated bright			

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  B. WING					(X3) DATE SURVEY COMPLETED 06/13/2023	
	ROVIDER OR SUPPLIER			12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
	C CARE OF CARM SUMMARY (EACH DEFICIEN			12999	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  enough to provide lighting in the stairwell.  The Maintenance Direct performed an inspection to en continuity of egress lighting for other designated stairs, aisless corridors, ramps, escalators, walkways and exit passages leading to the public way.  How will you identify all other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take.  All residents, visitors, and staff could be affected by the alleged deficient practice.  The Maintenance Direct performed an inspection to en continuity of egress lighting for other designated stairs, aisless corridors, ramps, escalators, walkways and exit passages leading to the public way.  What measures will be put implace or what systemic changes you will make to	he or sure r all f, er al or sure r al	(X5) COMPLETION DATE
					ensure the deficient practice will not recur?  The Maintenance Direct will monitor designated stairs, aisles, corridors, ramps, escalators, walkways and exit passages leading to the public way for continuity of egress lighting for four weeks and at I	or : :	

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monthly thereafter as a required task added to the TELS system to

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	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMEN	OT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/13/2023				
	PROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE			
				ensure continuity in egress lighting leading to the public work. The Maintenance Director will monitor the egress doors equipped with delayed egress systems weekly for four weeks and at least monthly thereafter a required task added to the T system to ensure that all egrest doors with delayed egress systems are functioning proper.  How will the corrective action(s) be monitored to ensure the deficient practice will not recur?  The Executive Director/designee will completed Life Safety CQI audit tool daily seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintain for two consecutive quarters. If threshold of 100% is not achied an action plan will be developed assure compliance.  The Maintenance	or s r as rELS ss rrly. re a r for				

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meetings.

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Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan.

Maintenance Director/designee will also review the results with the Safety Committee at their monthly

The Safety Committee will monitor results of the inspections

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155618	B. WING 06/13/2023			/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in			and report to the Continuous Quality Improvements Commit on their results from the inspections.  The Maintenance Direct and Administrator are respons for these results.	or	
	a. Boiler and Fuel b. Laundries (large c. Repair, Mainter	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops boms (exceeding 64					

e. Trash Collection Rooms

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618			(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 06/13/2023		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE (	(X5) COMPLETION DATE	
	(over 50 square feg. Laboratories (if Hazard - see K32 Based on observatifailed to ensure 1 of such as storage root properly working storage ficient practice coresidents, as well as Activities Office.  Findings include:  Based on observative Director on 06/13/23 during p.m. and 1:45 p.m., than 50 square feet items, such as, pape boxes. The corridor not equipped with a did not self-close as Director and the M of discovery and agon the Executive Director on a self-close in the Executive Director on the square feet items, such as, paper boxes. The corridor of equipped with a did not self-close as Director and the M of discovery and agon the Executive Director of the same feet items.	orage Rooms/Spaces eet) classified as Severe	K 0321	K 321 HAZARDOUS ENCLOSURES Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rowas provided with a properly working self-closing device. Findings include: Based on observations and interview with the Executive Director and Maintenance Director on 06/13/23 during a facility to the Activities Office, greater the 50 square feet contained sever combustible items, such as, paper, plastic, and carboard boxes. The corridor door to the office suite was not equipped a self-closing mechanism and not self-close and latch into the door frame.  What corrective action(s) will be accomplished for those reside found to have been affected be practice?  The Maintenance Direct serviced the door to the Activity office to ensure that the door closes and latches to the door closes and latches to the door frame.  The Maintenance Direct	s oom, ector our nan eral is with I did ne be ents oy this tor ties was self	08/01/2023	

performed an inspection of all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/13/2023	
	PROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				other storage areas to ensure storage areas are equipped w functional self-closing mechar and that each storage door latches to the door frame.	vith a
				How will you identify all other residents having the potentiato be affected by the same deficient practice and what corrective action will be take.  All residents, visitors, and staff could be affected by the alleged deficient practice.  The Maintenance Direct performed an inspection of all other storage areas to ensure storage areas are equipped with functional self-closing mechaniand that each storage door latches to the door frame.	en?  tor that
				What measures will be put in place or what systemic changes you will make to ensure the deficient practice will not recur?  The Maintenance Direct will monitor the hazardous are doors to ensure they self closs and latch to the doorframe we for four weeks and at least monthly thereafter as a require task added to the TELS system ensure that all egress doors we delayed egress systems are functioning properly.	tor ea e eekly ed m to

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How will the corrective

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/13/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032					
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE COMPLETION DATE			
				action(s) be monitored ensure the deficient prawill not recur?  The Executive Director/designee will conclude Safety CQI audit too seven days; weekly for seven	mplete a I daily for even er to aintained ters. If achieved veloped to  executive ife Safety ed will be via signee ts with the ir monthly ttee will pections ious ommittee			
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLET			LETED
		155618	B. WING 06/13/2023				/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	L					
MA IEST	IC CARE OF CARM	<b>1</b> ⊑1	12999 N PENNSYLVANIA ST CARMEL, IN 46032				
IVIAJEST	. CANL OF CARIV			CARIVIE	, 114 +0032		
(X4) ID	SUMMARY S	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		LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		IFPA 25, Standard for the					
	Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.						
	•	n design, maintenance,					
		ting are maintained in a					
		nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in PEMAE	PKS information on					
	Provide in REMARKS information on coverage for any non-required or partial						
	automatic sprinkle	·					
	9.7.5, 9.7.7, 9.7.8,	=					
		on and interview, the facility	K 0	353	K 353 SPRINKLER SYSTEM	_	08/01/2023
		ne ceiling construction of 4 of 4	1 1 0.	555	MAINTENANCE AND TESTIN		00/01/2023
		The ceiling tiles trap hot air			Based on observation and	<u>~</u>	
		e sprinkler and cause the			interview, the facility failed to		
	_	at a specified temperature.			maintain the ceiling construction	on	
		tion, 8.5.4.11 states the distance			of 4 of 4 closets and rooms. T		
		er deflector and the ceiling			ceiling tiles trap hot air and		
	_	eted based on the type of			gasses around the sprinkler a	nd	
		pe of construction. This			cause the sprinkler to operate		
	deficient practice af				specified temperature.		
					Findings include:		
	Findings include:				Based on observation and		
					interview with the Executive		
	Based on observation	on and interview with the			Director and the Maintenance		
		and the Maintenance Director			director on 6/13/23 The		
		a facility tour between 12:05			suspended ceiling had missing	a	
	_	the suspended ceiling had			panels in the following location	-	
		e following locations:			A) The IT Storage closet.	· ·	
	A) The IT storage of	_			B) All linen closets on the N	orth	
		on the North Hall, first and			Hall, first and second floor.		
	second Floor.	,			C) The Med Room at the fir	st	
		at the 1st floor nurses station.			floor nurses station.	•	
		ctor stated he was unsure why			What corrective action(s) wil	I	

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so many ceiling tiles were missing.

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be accomplished for those

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155618	A. BUILDING 01 B. WING			COMPLETED 06/13/2023	
		133010	Б. W	_		00/13/	72023
	PROVIDER OR SUPPLIE			12999	ADDRESS, CITY, STATE, ZIP COD  N PENNSYLVANIA ST		
MAJEST	IC CARE OF CAR	MEL		CARM	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	residents found to have been	•	DATE
	This finding was a	cknowledged by the Executive			affected by this practice?	1	
		Inintenance Director at the time			· A) The Maintenance		
	of discovery and a	gain at the exit conference with			Director replaced ceiling tiles	that	
	the Executive Dire	ector, Maintenance Director, and			had been removed on the IT		
	Assistant Maintena	ance personnel present.			storage closet.		
	2.1.10(1)				B) The Maintenance		
	3.1-19(b)				Director replaced ceiling tiles that been removed in the liner		
					closets on the North Hall on b		
					first and second floor.	our	
					· C) The Maintenance		
					Director replaced the ceiling ti	les	
					that had been removed in the	Med	
					Room at the first floor nursing		
					station.		
					How will you identify all other		
					residents having the potentia	al	
					to be affected by the same		
					deficient practice and what corrective action will be take	n?	
					· All residents, visitors, ar		
					staff could be affected by the		
					alleged deficient practice.		
					· A) The Maintenance		
					Director replaced ceiling tiles	that	
					had been removed on the IT storage closet.		
					B) The Maintenance		
					Director replaced ceiling tiles	that	
					had been removed in the liner		
					closets on the North Hall on b	oth	
					first and second floor.		
					· C) The Maintenance	loo	
					Director replaced the ceiling to that had been removed in the		
					Room at the first floor nursing		
					station.		
					· The Maintenance Direct	or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155618	B. W	B. WING		06/13/2023	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					N PENNSYLVANIA ST		
MAJEST	IC CARE OF CARN	ΛEL		CARM	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUBERG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE	DATE
					reviewed all ceiling tiles in the		
					facility to ensure that the ceilir		
					tiles are properly in place in	.5	
					accordance with the NFPA.		
					asserdance war are ru i / a		
					What measures will be put in	nto	
					place or what systemic		
					changes you will make to		
					ensure the deficient practice		
					will not recur?		
					· The Maintenance Direct	or	
					will monitor the ceiling tiles we		
					for four weeks and at least	only	
					monthly thereafter as part of		
					environmental rounds and set	it as	
					a required task added to the T		
					system to ensure compliance.		
					system to ensure compliance.		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur?		
					· The Executive		
					Director/designee will complet	e a	
					Life Safety CQI audit tool daily		
					seven days; weekly for seven		
					weeks; monthly thereafter to		
					monitor compliance until		
					compliance has been maintain	ned	
					for two consecutive quarters.		
					Daily Construction Audit will b		
					completed daily until construc		
					on the skilled nursing unit is		
					complete. If threshold of 1009	% ie	
					1		
					not achieved an action plan w developed to assure complian		
						ic <del>e</del> .	
					The Maintenance		
1	Ī				Director/designee and Execut	ive	1

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Director will review the Life Safety

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING  O  O  O  O  O  O  O  O  O  O  O  O  O	
155010 B. WING 00713	3/2023
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF CARMEL  STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  CQI and Daily Construction Audit. Any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings.  The Safety Committee will monitor results of the inspections and report to the Cortinuous Quality improvements Committee on their results from the inspections.  The Maintenance Director and Administrator are responsible for these results.  K 0361 SS=F Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.  18.3.6.1, 19.3.6.1 Based on interview and observation, the facility failed to ensure 1 of 1 dining area was not open to the corridor. LSC 19.3.6.1 states corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), 19.3.6.1 (7) states places, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided that all of the following criteria are met; (a) The space and	08/01/2023

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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. BU	JILDING	01	COMPL	ETED
		155618	B. W	ING		06/13/	/2023
		l		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			N PENNSYLVANIA ST		
МД ІЕСТ	IC CARE OF CARM	<b>4</b> E1			EL, IN 46032		
IVIAJEST	OAKE OF CARI	//LL		CAINIVIE	L, IIV 4000Z		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<del>                                     </del>	TAG	DEFICIENCY)		DATE
	in the same smoke compartment, are protected by				hazardous areas, shall be		
	an electrically supervised automatic smoke				permitted to be open to the		
		accordance with 19.3.4. (b)			corridor and unlimited in area		
	Each space is protected by automatic sprinklers,				provided that all of the following	•	
	_	and furniture, in combination			criteria are met: (a) The space		
	with all other combustibles within the area, are of				the corridor into which it open		
	_	ntity and arrangement that a			where located in the same sm		
	fully developed fire is unlikely to occur. (c) The				compartment, are protected b	y an	
	_	ruct access to required exits.			electronically supervised		
	•	ice could affect all on the 2nd			automatic smoke detection		
	floor.				system in accordance with 19		
	Findings include:				(b) Each space is protected by	y	
					automatic sprinklers, or the		
					furnishings and Furniture, in		
		on and interview with the			combination with all combustil	oles	
		and the Maintenance Director			within the area are of such		
	_	a facility tour between 12:05			minimum quantity and		
	1	the newly renovated space			arrangement that a fully devel	-	
	_	n #2 in LTC was open to the			fire is unlikely to occur. (c) the		
		removal of the doors and			space does not obstruct acces	SS	
	_	rvised smoke detection was			to required exits.		
	1 ~	mentioned dining room. Based			Findings include:		
		time of observation, the			Based on observation and		
		tor stated the area was recently			interview with the Executive		
	renovated.				Director and the Maintenance		
					director on 6/13/23, the newly		
	_	knowledged by the Executive			renovated space called dining		
		aintenance Director at the time			room #2 in LTC was open to t		
		gain at the exit conference with			corridor due to the removal of	the	
		ctor, Maintenance Director, and			door and the windows. No		
	Assistant Maintena	nce personnel present.			supervised smoke detection w		
					present in the aforementioned		
	3.1-19(b)				dining room.		
					What corrective action(s) wil	I	
					be accomplished for those		
					residents found to have been	n	
					affected by this practice?		
					· The Maintenance Direct	or	
					facilitated installation of an		
			1		electronically supervised		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/13/2023		
	ROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
MAJESTIC CARE OF CARMEL  (X4) ID SUMMARY STATEMENT OF DEP PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING I	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  automatic smoke detection system in Dining Room #2 L accordance with 19.3.4. Dini Room #2 LTC was already protected by automatic sprin and does not obstruct any e The Maintenance Dire performed an inspection of areas in facility open to the corridor to ensure that the ro are equipped with electronic supervised automatic smoke detection system and do not obstruct exits in accordance the code.  How will you identify all oth residents having the poten to be affected by the same	COMPLETION DATE  TC in ing aklers exits. ctor all coms eally et with	
				deficient practice and what corrective action will be tall.  All residents, visitors, a staff on the 2nd floor could be affected by the alleged defice practice.  The Maintenance Director performed an inspection of a areas in facility open to the corridor to ensure that the roare equipped with electronic supervised automatic smoked detection system and do not obstruct exits in accordance the code. No additional deficiencies noted.  What measures will be put place or what systemic	ken? and be cient ctor all booms cally e t with

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changes you will make to ensure the deficient practice

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01		E SURVEY PLETED 3/2023		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE		
				will not recur?  The Maintenance Divill review all new construith the assistance of a fill professional to ensure an renovated areas are committee code.  How will the corrective action(s) be monitored to ensure the deficient practive action(s) be monitored to ensure the deficient practive.  The Executive Director/designee will consider the CQI audit tool seven days; weekly for seven days	octice  mplete a daily for even r to intained eloped to directive fe Safety d through ddressed e action or review y lly tee will pections ous			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155618		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPL 06/13/	ETED			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CORRECTION (X5) ON SHOULD BE THE APPROPRIATE Y) COMPLETIC DATE			
				<ul> <li>The Maintenand and Administrator are for these results.</li> </ul>				
K 0363 SS=E Bldg. 01	than required encexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I CMS regulation. The apply to auxiliary app	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are led protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155618	B. W	NG		06/13	/2023
NAME OF I	DROLUDED OD CUIDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		12999 1	N PENNSYLVANIA ST		
MAJESTIC CARE OF CARMEL				CARME	EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		Y OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)			DATE		
	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.						
		on and interview, the facility	K 0	363	K 363 CORRIDOR - DOORS		08/01/2023
	failed to ensure all corridor doors had no impediment to closing and latching into the door				Based on observation and		
	frame and would resist the passage of smoke.				interview, the facility failed to ensure all corridor doors had	no	
	This deficient practice could affect 6 staff and 15				impediments to closing and	110	
	residents.				latching into the door frame a	nd	
	residents.				would resist the passage of	ii G	
	Findings include:				smoke. The deficient practice		
					could affect 6 staff and 15		
	Based on observation	on and interview with the			residents.		
	Executive Director	and the Maintenance Director			Findings include:		
	on 06/13/23 during	a facility tour between 12:05			Based on observation and		
	p.m. and 1:45 p.m.,	the following corridor doors			interview with the Executive		
	failed to latch positi	ively into their respective door			Director and the Maintenance		
	frames:				director on 6/13/23, the follow	ving	
		1 to the corridor did not have			corridor doors failed to latch		
	~	Only a claw type manual turn			positively into their respective	door	
		on the door, and it did not			frames:		
	1	when closed. The Executive			a) Therapy Door #1 to the		
		this door had recently been			corridor did not have latching		
	installed.	2. 4			hardware. Only a claw type		
		2 to the corridor did not have			manual turn knob was installe	d on	
	~	Only a claw type manual turn on the door, and it did not			the door, and it did not	- al	
		when closed. The Executive			automatically latch when close	ea.	
	1	this door had recently been			b) Therapy Door #2 to the corridor did not have latching		
	installed.	ans door had recently been			hardware. Only a claw type		
		room corridor door, equipped			manual turn knob was installe	d on	
	l '				the door, and it did not	G OII	
	with a self-closing device, failed to close and latch.				automatically latch when close	ed.	
		tor and Director of Nursing			c) 1st floor Cable room cor		
		oor was held open with a brick.			door, equipped with a self clos		
		The Executive Director agreed the brick would			device, failed to close and late	-	

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 06/13/2023			
ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032					
SUMMARY (EACH DEFICIEN REGULATORY OF impede the doors' a  This finding was ac Director and the Moof discovery and ag the Executive Director	R MEL STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	STREET 12999	N PENNSYLVANIA ST	with a  ill  vare  ns door  vare  ns door  that it hes  blding or of The om			
			was immediately educated n use of objects to obstruct the office door from closing.  How will you identify all oth				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/13/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				residents having the potentia to be affected by the same deficient practice and what corrective action will be take.  All residents, visitors, an staff have the potential to be affected by the alleged deficie practice.  The Maintenance Direct performed an audit of all corrid doors in the facility to all self closing doors close completely and latch to the door frame Of otherwise impeded from closing and latch firmly to the door frame What measures will be put in place or what systemic changes you will make to ensure the deficient practice will not recur?  Staff were provided in-service training on the stand in NFPA 101 Corridor – Doors specifically focusing on the requirement that corridor door must latch and close automatically if there is a close.  The Executive Director/designee will complet Life Safety CQI audit tool daily seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintain for two consecutive quarters. It threshold of 100% is not achie an action plan will be developed assure compliance. Audit will	en?  Ind  Int  Int  Int  Int  Int  Int  Int		

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also be completed at the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155618	B. WING			06/13/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			N PENNSYLVANIA ST		
MAJEST	IC CARE OF CARM	<b>Λ</b> ΕΙ			EL, IN 46032		
W/ WESTIS STATE OF STATES				O/ (I (IVIL	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					conclusion of construction in		
					addition to the CQI schedule s	et	
					forth above.		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur?		
					· The Executive		
					Director/designee will complet		
					Life Safety CQI audit tool daily	/ for	
					seven days; weekly for seven		
					weeks; monthly thereafter to		
					monitor compliance until		
					compliance has been maintair		
					for two consecutive quarters.		
					threshold of 100% is not achie		
					an action plan will be develope	ed to	
					assure compliance. Audit will		
					also be completed at the		
					conclusion of construction in		
					addition to the CQI schedule s	set	
					forth above.		
					· The Maintenance		
					Director/designee and Execut		
					Director will review the Life Sa	itety	
					CQI and any issues identified		
					through the CQI process will be	e	
					addressed immediately via		
					corrective action plan.		
					Maintenance Director/designe		
					will also review the results with		
					Safety Committee at their mor	ntnly	
					meetings.	•••	
					The Safety Committee v		
					monitor results of the inspection	ons	
					and report to the Continuous		
					Quality Improvements Commi	ttee	
					on their results from the		
1					inspections.		1

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The Maintenance Director

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155618	B. Wl	B. WING			/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				N PENNSYLVANIA ST		
MAJESTI	C CARE OF CARM	IEL		CARMEL, IN 46032			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IE	DATE
					and Administrator are respons	ible	
					for these results.		
K 0761							
SS=F							
Bldg. 01							
		on, records review, and	K 0	761	K 761 Maintenance, Inspection	on,	08/01/2023
		ty failed to ensure annual			Testing - Doors		
	•	ng of 9 of 9 fire door mpleted in accordance of LSC			Based on observation, record	it.	
		-			review, and interview; the facil failed to ensure annual inspec	•	
	19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be				and testing of 9 of 9 fire door	lion	
	permitted only in corridors and shall be protected				assemblies were completed		
	by approved self-closing fire door assemblies.				Findings include:		
		3.) LSC 8.3.3.1 Openings			Based on records review and		
	,	re protection rating by Table			interview with the Executive		
	-	ected by approved, listed,			Director and the Maintenance		
	_	semblies and fire window			director on 6/13/23,		
	assemblies and their	accompanying hardware,			documentation of an annual		
	including all frames	, closing devices, anchorage,			inspection of fire door assemb	lies	
	and sills in accordar	nce with the requirements of			8/01/2023d 5/25/23 showed 5		
	·	for Fire Doors and Other			passed and 11 failed doors. T		
		s, except as otherwise			provided inspection report did		
	•	de. NFPA 80 5.2.1 states fire			include the door leading from t		
		ll be inspected and tested not			Environmental Services Office		
	<u>-</u>	and a written record of the			the Laundry area, which is par		
	-	signed and kept for inspection 80, 5.2.4.1 states fire door			the fire wall assembly. During		
	•	visually inspected from both			tour several doors and door Ja		
		verall condition of door			assemblies were missing tags indicating the ratings. The		
		), 5.2.4.2 states as a minimum,			Maintenance Director stated the	nat a	
	the following items				company had been hired to co		
	_	r breaks exist in surfaces of			and certify the aforementioned		
	either the door or fra				doors and provide/install the	-	
		ight frames, and glazing beads			appropriate rating plates.		
		ely fastened in place, if so					
	equipped.				What corrective action(s) wil	I	
		, hinges, hardware, and			be accomplished for those		
		eshold are secured, aligned,			residents found to have beer	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155618	B. WING 06/13/2023			06/13/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8	12999 N PENNSYLVANIA ST				
MAJEST	IC CARE OF CARM	1EL	CARMEL, IN 46032				
_			1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  PLICE IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION  er with no visible signs of		TAG		DATE	
	damage.	er with no visible signs of			affected by this practice?  All 11 doors identified in	tho	
(4) No parts are missing or broken.					annual inspection on 5/23/23		
	(5) Door clearances do not exceed clearances				having failed inspection were	as	
	listed in 4.8.4 and 6.3.1.7.				evaluated and certified accord	lina	
					to NFPA.	mig	
	(6) The self-closing device is operational; that is, the active door completely closes when operated				The door leading from the	ne	
	from the full open p				Environmental Services Office		
		is installed, the inactive leaf			the Laundry area identified on		
	closes before the ac				facility tour was also evaluated		
		are operates and secures the			and certified accordingly.	<b>-</b>	
	door when it is in the closed position.				and contined decoratingly.		
	(9) Auxiliary hardware items that interfere or				How will you identify all other	er	
		re not installed on the door or			residents having the potential		
	frame.				to be affected by the same		
	(10) No field modif	ications to the door assembly			deficient practice and what		
		ed that void the label.			corrective action will be take	en?	
	_	edge seals, where required, are			· All residents, visitors, ar		
		their presence and integrity.			staff have the potential to be		
		ice could affect all residents.			affected by the alleged deficie	ent	
	_				practice.		
	Findings include:				· The Maintenance Direct	or	
					performed an audit of all door	s and	
	Based on records re	view and interview with the			door jambs in the facility to en	sure	
	Executive Director	and the Maintenance Director			that all door and door jamb		
		n 8:45 a.m. and 12:05 p.m. and			certifications were tagged		
		en 12:05 p.m. and 1:45 p.m.,			indicating their appropriate rat	ings.	
		n annual inspection of fire					
		ed 5/25/23 showed 5 passed			What measures will be put in	nto	
		The provided inspection			place or what systemic		
	-	de the door leading from the			changes you will make to		
		vices office into the Laundry			ensure the deficient practice	)	
	_	of the fire wall assembly.			will not recur?		
	-	eral doors and door jamb			The Maintenance Direct	or	
		ssing tags indicating the			will perform an inspection of		
	ratings. The Maintenance Director stated that a				facility door jambs and doors	every	
		hired to come and certify the			six months and after any		
		ors and provide/install the			construction to ensure ratings		
	appropriate rating p	lates.			affixed at least every six mont	hs.	
					<ul> <li>The Executive</li> </ul>		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/13/2023		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE		
1AG	This finding was ac Director and the M of discovery and ag the Executive Direc	eknowledged by the Executive aintenance Director at the time gain at the exit conference with ctor, Maintenance Director, and nice personnel present.	TAG	Director/designee will comp Life Safety CQI audit tool da seven days; weekly for seve weeks; monthly thereafter to monitor compliance until compliance has been maint for two consecutive quarters threshold of 100% is not act an action plan will be devel assure compliance. Audit w also be completed at the conclusion of construction in addition to the CQI schedule forth above.  How will the corrective action(s) be monitored to ensure the deficient practi will not recur?  The Executive Director/designee will comp Life Safety CQI audit tool da seven days; weekly for seve weeks; monthly thereafter to monitor compliance until compliance has been maint for two consecutive quarters threshold of 100% is not act an action plan will be devel assure compliance. Audit w also be completed at the conclusion of construction in addition to the CQI schedule forth above.  The Maintenance Director/designee and Exec Director will review the Life CQI and any issues identifie through the CQI process wi addressed immediately via corrective action plan.	elete a aily for en o ained s. If hieved oped to vill n e set  ce  elete a aily for en o cained s. If hieved oped to vill n e set		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155618	B. WING 06/1:			06/13	/2023
	PROVIDER OR SUPPLIE			12999 N	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0927 SS=F	NFPA 101 Gas Equipment -	Transfilling Cylinders			Maintenance Director/designe will also review the results with Safety Committee at their more meetings.  The Safety Committee we monitor results of the inspection and report to the Continuous Quality Improvements Committee on their results from the inspections.  The Maintenance Direct and Administrator are responsitor these results.	n the nthly vill ons ttee	
Bldg. 01	Transfilling of oxy another is in accordance of Higo Oxygen Used for any gas from one prohibited in patie to liquid oxygen occurainers over 5 under 11.5.2.3.1 liquid oxygen concontainers under	Transfilling Cylinders agen from one cylinder to bridance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is ent care rooms. Transfilling containers or to portable 0 psi comply with conditions (NFPA 99). Transfilling to tainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99). 9)					
	Based on observati failed to ensure 1 or room was provided transferring is occu 99 11.5.2.3.1(3) state signs indicating that that smoking is the	on and interview, the facility  f 1 oxygen storage/transfer  with a sign indicating that  urring and not occurring. NFPA  ates, the area is posted with  at trans-filling is occurring, and  immediate area is not  ficient practice could affect all	K 09	927	K 927 GAS EQUIPMENT – TRANSFILLING CYLINDERS Based on observation and interview, the facility failed to ensure that 1 of 1 oxygen storage/transfer was provided sign indicating that transferring occurring and not occurring. NFPA 99 11.5.2.3.1(3) states, area is posted with signs	g is	08/01/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155618			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/13/2023
	PROVIDER OR SUPPLIER		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
MAJEST  (X4) ID  PREFIX  TAG	SUMMARY:  (EACH DEFICIEN REGULATORY OR Findings include:  Based on observation Executive Director on 06/13/23 during p.m. and 1:45 p.m., room near the elevation indicating when transition the sign suggests. Based on interview Maintenance Direct stating when transitions when it was not.  This finding was act Director and the Mator of discovery and agt the Executive Director.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION  on and interview with the and the Maintenance Director a facility tour between 12:05 the oxygen storage/transfer tor, did not have a posted sign insferring of oxygen occurs in men it is not occurring. The set that it is always occurring at the time of observation, the for stated there was not a sign filling oxygen is occurring and who who will be the sain at the exit conference with tor, Maintenance Director, and ince personnel present.			en e d ding and ll n or ide r that o g not.  er al en?

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	OF CORRECTION	IDENTIFICATION NUMBER  155618	A. BUILDING B. WING	01	COMPLETED 06/13/2023
	ROVIDER OR SUPPLIER		12999 1	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE	
				replaced the posted sign outsi of the Oxygen storage/transferoom near the elevator, which indicated that transfilling was always occurring, with a sign to can be manipulated by staff to reflect when oxygen transfilling was occurring and when it is not what measures will be put in place or what systemic changes you will make to ensure the deficient practice will not recur?  The Maintenance Direct replaced the posted sign outsi of the Oxygen storage/transferoom near the elevator, which indicated that transfilling was always occurring, with a sign to can be manipulated by staff to reflect when oxygen transfilling was occurring and when it is not occurring and when it is not occurring and transferring, inclus but not limited to the use of the new sign to indicate when transfilling is and is not occurring.  How will the corrective action(s) be monitored to ensure the deficient practice will not recur?  The Executive  Director/designee will complete Life Safety CQI audit tool daily seven days; weekly for seven weeks; monthly thereafter to monitor compliance until	hat g not. ito  or de r hat g not. ding e ing.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/13/2023	
	PROVIDER OR SUPPLIE	R	STREET 12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	00/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	N
				for two consecutive quarters. threshold of 100% is not achinal action plan will be develop assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule forth above.  The Maintenance Director/designee and Execut Director will review the Life ScQI and any issues identified through the CQI process will addressed immediately via corrective action plan. Maintenance Director/designe will also review the results with Safety Committee at their momeetings.  The Safety Committee with monitor results of the inspection and report to the Continuous Quality Improvements Common their results from the inspections.  The Maintenance Director and Administrator are responsion these results.	eved bed to I set tive afety be the the nthly will sons ittee tor	

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