I	DEPARTMENT OF HEALTH AND HU	MAN SERVICES		
(	CENTERS FOR MEDICARE & MEDIC	AID SERVICES		
ſ	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	
П	AND DE AN OF CORRECTION	IDENTIFICATION AND OPEN	A DIM DDIG	

	OF CORRECTION	IDENTIFICATION NUMBER  155618		JILDING	DNSTRUCTION	COMPL 08/03/	ETED
	ROVIDER OR SUPPLIER			12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID PREFIX TAG E 0000 Bldg	(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)	ΤΕ	(X5) COMPLETION DATE
blug	Preparedness Survey conducted by the In accordance with 42 Survey Dates: 08/0 Facility Number: 0 Provider Number: 200 At this PSR Emerge Majestic Care of Ca with Emergency Prometer and Medicand Suppliers, 42 C	2/23 - 08/03/23  01149 155618 145500  ency Preparedness survey, rmel was found in compliance eparedness Requirements for caid Participating Providers FR 483.73.  certified beds. At the time of us was 54.	E 00	000	K000 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 deficiencies 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 8/18/2023	ot s forth s or This the e	
K 0000 Bldg. 01							
	Code Recertification that exited on 06/13	01149 155618	K 0	000	K000 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 deficiencies 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	ot s forth s or This the	

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

(X6) DATE

TITLE

John Seib Executive Director 08/25/2023

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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	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 08/03/2023
	PROVIDER OR SUPPLIEF		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
	Care of Carmel was Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code (I Health Care Occupa This two-story facil Type II (111) const The facility has a fi detection in the cor corridors, and hard- resident rooms. The facility has a capaci 54 at the time of thi All areas where res were sprinklered an services were sprink	, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.  ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors, spaces open to the wired smoke detectors in all the healthcare portion of the fity of 104 and had a census of s PSR visit.		REVISIT on or after 8/18/2023	3.
K 0211 SS=E Bldg. 01	discharges, exit lot 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 observation failed to insure that direction of egress to the dire	- General ays, corridors, exit cations, and accesses are n Chapter 7, and the means accussly maintained free of full use in case of s modified by 18/19.2.2 1. 1.10.1 on and interview the facility all exit doors opened in the cravel. NFPA 101 7.2.1.4.2	K 0211	K 211 MEANS OF EGRESS Based on observation and interview, the facility failed to	11/30/2023
		ves required to be of the ted-swinging type shall swing		ensure that all exit doors oper in the direction of egress trave	

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Event ID:

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Facility ID: 001149

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	ENT OF DEFICIENCIES IN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/03/2023
	F PROVIDER OR SUPPLIEF		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE PROPERTY OF THE PROP	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	in the direction of e following condition (1) Where serving a occupant load of 50 the following condition (a) Door leaves in he required to swing in where permitted by (b) Door leaves in sequired to swing in existing health can be compared to make and staff of the compared to the original survey which stated push for in the original survey which stated push for infact the door pull birector commented doors didn't open in such doors were reposed to doors were reposed to the survey of th	a room or area with an or more, except under any of tions: norizontal exits shall not be a the direction of egress travel 7.2.4.3.8.1 or 7.2.4.3.8.2. Impose barriers shall not be a the direction of egress travel are occupancies, as provided in efficient practice could affect 25 exiting through the stairwells.  It tour and interview with the and the Maintenance Director on 12:01 p.m. and 12:50 p.m., the exit door near resident room # exit, opened into the building tion of egress travel. This door by was cited for having a sign for 15 sec delayed egress when is inward. The Executive dithat he wasn't sure why the atto the stairwell and that two blaced a year ago. The cor said that the vendor had aying "pull for 15 sec delayed ailable and the facility had	TAG	NFPA states that door lear required to be of the side-him pivoted-swinging type shall sin the direction of egress travel.  Based on a facility tour and interview with the Executive Director and the Maintenance director on 08/03/23 The fifloor stairwell exit door near resident room #138, marked exit, opened into the building not in the direction of egress travel.  What corrective action(s) will accomplished for those reside found to have been affected practice?  The facility has request temporary waiver of the requirement for the first floor stairwell exit door near residencom #138. Waiver requested 11/23/2023. Attached.  The facility has ordered new door and frame to replantifiest floor stairwell exit door near resident room #138. However contractor indicated that the and frame would need to be fabricated and that this would between 8 and 10 weeks for and then an additional 3 week complete the install. Attached to be affected by the same deficient practice and what corrective action will be taken as a strong w	e rst as an and be lents by this ted ent ed till da ce the ear er the door d take parts eks to d.
1	1 1 1-19(0)		1	I COMPACTIVE SCHOOL WILL BO 194	

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

PRINTED: 09/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155618	B. Wl	NG	·	08/03/	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			N PENNSYLVANIA ST		
MAJEST	IC CARE OF CARI	MEI			EL, IN 46032		
IVII/ (OLO)	10 0/11/2 01 0/11/1	vice		O/ ti tivii			
(X4) ID		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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					· All residents, visitors, ar		
					staff who would use the first fl		
					stairwell exit door near reside		
					room #138 have the potential		
					affected by the alleged deficie	nt	
					practice.		
					The Maintenance Direct		
					performed a functional inspec		
					of all means of egress to ensu that all facility doors in the pat		
					egress swing in the direction of		
					egress travel.	וכ	
					· Audit Completed 8/18/2	الد ۶	
					other doors in the facility in the		
					path of egress swing in the		
					direction of egress travel.		
					an oction of ogress travel.		
					What measures will be put in	nto	
					place or what systemic		
					changes you will make to		
					ensure the deficient practice		
					will not recur?		
					· A replacement door and		
					frame has been ordered to rep	olace	
					the first floor stairwell exit doo	r	
					near resident room #138.		
					· First Floor Stairwell exit		
					door near resident room #138		
					part of the original constructio	n of	
					the building and facility is		
					requesting a temporary waive	r of	
					the standard considering		
					corrective action i.e. replacem		
					will take more than ninety (90)	)	
					days to complete.		
					Facility has engaged in		
					electronic and direct in-service		
					training with staff to increase t	ire	
					safety awareness while		
1					noncompliance is being corre	cted.	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/05/2023
FORM APPROVED
OMP NO. 0038 030

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01				01	COMPI	LETED
		155618	B. W	ING		08/03	/2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	<u>t</u>		12999 I	N PENNSYLVANIA ST		
MAJEST	IC CARE OF CARM			CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Specifically:		
					o Relias: Fire Prevention an	d	
					Response: The Basics		
					o In Person: Means of Egres		
					the event of a fire: First Floor		
					Carmel SNF.		
					· The Executive		
					Director/designee will complet		
					Life Safety CQI Egress Doors		
					audit tool weekly to ensure do		
					swing in the direction of egres		
					travel and are functioning prop	perly.	
					The Executive Director or		
					designee will monitor egress of		
					with regular walking rounds to	1	
					ensure continued compliance		
					between weekly audits. Resul		
					the Monitoring will be reviewed		
					weekly and during the facility's	5	
					Quality Assurance meeting.	_	
					Monitoring will be ongoing.	Any	
					deficiency will be addressed	/	
					immediately. If threshold of 10		
					is not achieved an action plan	WIII	
					be developed to assure		
					compliance.		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice	•	
					will not recur?		
					· The Executive		
					Director/designee will complet	te a	
					Life Safety CQI Egress Doors		
					audit tool weekly to ensure do		
					swing in the direction of egres		
					travel and are functioning prov		

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The Executive Director or

designee will monitor egress doors with regular walking rounds to

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

PRINTED: 09/05/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/03/2023
	PROVIDER OR SUPPLIEF		12999	ADDRESS, CITY, STATE, ZIP COI N PENNSYLVANIA ST EL, 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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE
				ensure continued complibetween weekly audits. Ithe Monitoring will be revieweekly and during the far Quality Assurance meeting. Monitoring will be ongoing deficiency will be address immediately. If threshold is not achieved an action be developed to assure compliance.  The Maintenance Director/designee and E Director will review the L CQI Egress Doors and a didentified through the CO will be addressed immediately also review the result Safety Committee at the meetings.  The Safety Committee at the meetings.  The Safety Commitmonitor results of the instand report to the Continual Quality Improvements C on their results from the inspections.  The Maintenance I and Administrator are refor these results.	Results of viewed cility's ng. ng. ng. Any sed d of 100% n plan will executive ife Safety any issues all process diately via esignee ts with the ir monthly ttee will expections yous ommittee
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou	corridor openings in other losures of vertical openings, s areas resist the passage made of 1 3/4 inch			

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

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	OF CORRECTION	IDENTIFICATION NUMBER  155618		ILDING	01	COMPL 08/03/	ETED
	PROVIDER OR SUPPLIER		-	12999 N	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller It CMS regulation. The apply to auxiliary a flammable or complying the doors complying with the door closed with a complete when the permitted. Nonrate unlimited height a meeting 19.3.6.3.4 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc.	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 then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire as or frames in window  Parts 403, 418, 460, 482, as details of doors such as angs, automatics closing					
	failed to ensure all of impediment to closing	on and interview, the facility corridor doors had no ing and latching into the door sist the passage of smoke.	K 03	363	K 363 CORRIDOR - DOORS  Based on observation and interview, the facility failed to ensure all corridor doors had recorded to the control of t	10	08/18/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	r í	JILDING	onstruction  01	(X3) DATE : COMPL 08/03/	ETED
	PROVIDER OR SUPPLIE			12999 N	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	This deficient practives deficients.  Findings include:  Based on observative Executive Director tour the Therapy Dhave latching hards turn knob was instant automatically latch Director stated that installed. Additional corridor did not have claw type manual the door, and it did not closed. The Executed door hardware was week, and that the replace the hardware the hardware was birector at the time exit conference with present.  This deficiency was	eknowledged by the Executive of discovery and again at the h the Executive Director s cited on 06/13/23. The facility a systemic plan of correction		TAG	impediments to closing and latching into the door frame ar would resist the passage of smoke. The deficient practice could affect 6 staff and 15 residents. Findings include: Based on observation and interview with the Executive Director on 8/02/23 during a facility tour the Therapy Door at the corridor did not have latchinardware. Only a claw type manual turn knob was installed the door, and it did not automatically latch when closed this door was recently been installed. Additionally, Therapy Door #2 to the corridor did not have latching hardware. Only claw type manual turn knob was installed on the door, and it did automatically latch when closed the door hardware was supposed to be installed last week, and the vendor was coming today replace the hardware. This deficiency was cited on 06/13/23. The facility failed to implement a systemic plan of correction to prevent recurrence. What corrective action(s) will be accomplished for those residents found to have beer affected by this practice?  The Executive Director oversaw installation of latching hardware by Central Indiana.	#1 to ing d on ed. that d not ed. that sed that to ce.	DATE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  08/03/2023
NAME OF PROVIDER OR SUPPLIE		12999	ADDRESS, CITY, STATE, ZIP COD N PENNSYLVANIA ST EL, IN 46032	
PREFIX (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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
			Hardware (CIH) on Therapy de #1 on 8/9/2023. Therapy doo now functions with a self-closidevice and automatically latch to the door frame when closed See Attached.  The Executive Director oversaw installation of latching hardware by Central Indiana Hardware (CIH) on Therapy de #2 on 8/9/2023. Therapy doo now functions with a self-closidevice and automatically latch to the door frame when closed See Attached.  The facility will ensure deprotecting corridor openings we smoke resistive; have no impediments to closing; are self-latching and provided postlatching hardware. Ongoing, the Executive Director or designer monitor corridor doors to ensure continued compliance. Result the Monitoring will be reviewed during the facility's Quality Assurance meeting; Monitoring will be ongoing.  How will you identify all other residents having the potentiation be affected by the same deficient practice and what corrective action will be taken. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice and what corrective action will be taken.	oor r #1 ng nes d.  g oor r #2 ng nes d. oors rill be sitive he e will ure s of d g  pr al

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• The Maintenance Director performed an audit of all corridor

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CEN

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NTERS FOR MEDICARE & MEDICAID SERVICES OM					
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		
	155610	D WING	00/03/3033		

	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155618	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	COMP	E SURVEY PLETED 3/2023
	ROVIDER OR SUPPLIEI C CARE OF CARM		12999	ADDRESS, CITY, STATE, ZIP CO N PENNSYLVANIA ST EL, IN 46032	OD	
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	doors in the Facility on 8/18/23, to ensure doors protecting corridor open smoke resistive; have n impediments to closing; self-latching and provide latching hardware.  What measures will be place or what systemic changes you will make ensure the deficient pr will not recur?  Staff were provide in-service training on the in NFPA 101 Corridor — specifically focusing on requirement that corridor must latch and close automatically if there is  The Executive Director/designee will could be a safety CQI Corridor tool weekly to ensure do protecting corridor open smoke resistive; have n impediments to closing; self-latching and provide latching hardware. The Director or designee will corridor doors with regurounds to ensure contin compliance between we audits. Results of the M will be reviewed during facility's Quality Assurant	or before s sings are o are ed positive et to ed e standard Doors the or doors a closer.  omplete a r Door audit pors sings will be o are ed positive executive I monitor clar walking ued eekly onitoring the	DATE

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threshold of 100% is not achieved

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						1 13113	1ED. 03/06/2020	
DEPARTMENT	FORM APPROVED							
CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155618	B. WING		08/03/2023			
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			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	

MAJESTIC CARE OF CARMEL		CARM	CARMEL, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
			an action plan will be developed to assure compliance.			
			How will the corrective action(s) be monitored to ensure the deficient practice will not recur?  The Executive Director/designee will complete a Life Safety CQI Corridor Door audit tool weekly to ensure doors protecting corridor openings will be smoke resistive; have no impediments to closing; are self-latching and provided positive latching hardware. The Executive Director or designee will monitor corridor doors with regular walking rounds to ensure continued			
			compliance between weekly audits. Results of the Monitoring will be reviewed during the facility's Quality Assurance meeting; Monitoring will be ongoing. Any deficiency will be addressed immediately. If threshold of 100% is not achieved an action plan will be developed to assure compliance.			
			The Maintenance Director/designee and Executive Director will review the Life Safety CQI Corridor Door Audit Tool 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			

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICARD SERVICES							
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
155618			B. WING		08/03/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12999 N PENNSYLVANIA ST CARMEL, IN 46032				
(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:		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				meetings. The Safety Committee we monitor results of the inspection and report to the Continuous Quality Improvements Committ on their results from the inspections. The Maintenance Director and Administrator are respons	ons ttee or		

for these results.

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