STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155618	A. BUILDING -- B. WING	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	12999 N PENNSYLVANIA ST CARMEL, IN 46032

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 06/13/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 08/02/23 - 08/03/23 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this PSR Emergency Preparedness survey, Majestic Care of Carmel was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 104 certified beds. At the time of the survey, the census was 54. Quality Review completed on 08/11/23	E 0000	**K000** The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and **REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT** on or after 8/18/2023.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 06/13/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 08/02/23 - 08/03/23 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500	K 0000	**K000** The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and **REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Seib	Executive Director	08/25/2023

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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	At this PSR Life Safety Code survey, Majestic Care of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident rooms. The healthcare portion of the facility has a capacity of 104 and had a census of 54 at the time of this PSR visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/11/23		**REVISIT** on or after 8/18/2023.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview the facility failed to insure that all exit doors opened in the direction of egress travel. NFPA 101 7.2.1.4.2 states that Door leaves required to be of the side-hinged or pivoted-swinging type shall swing	K 0211	**K 211 MEANS OF EGRESS** Based on observation and interview, the facility failed to ensure that all exit doors opened in the direction of egress travel.	11/30/2023

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	in the direction of egress travel under any of the following conditions: (1) Where serving a room or area with an occupant load of 50 or more, except under any of the following conditions: (a) Door leaves in horizontal exits shall not be required to swing in the direction of egress travel where permitted by 7.2.4.3.8.1 or 7.2.4.3.8.2. (b) Door leaves in smoke barriers shall not be required to swing in the direction of egress travel in existing health care occupancies, as provided in Chapter 19. This deficient practice could affect 25 residents and staff exiting through the stairwells. Findings Include: Based on a facility tour and interview with the Executive Director and the Maintenance Director on 08/03/23 between 12:01 p.m. and 12:50 p.m., the first-floor stairwell exit door near resident room # 138, marked as an exit, opened into the building and not in the direction of egress travel. This door in the original survey was cited for having a sign which stated push for 15 sec delayed egress when if fact the door pulls inward. The Executive Director commented that he wasn't sure why the doors didn't open into the stairwell and that two such doors were replaced a year ago. The Maintenance Director said that the vendor had told her that signs saying "pull for 15 sec delayed egress" were not available and the facility had marked out push and written pull. . This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)		NFPA … states that door leaves required to be of the side-hinged or pivoted-swinging type shall swing in the direction of egress travel…. Findings include: Based on a facility tour and interview with the Executive Director and the Maintenance director on 08/03/23… The first floor stairwell exit door near resident room #138, marked as an exit, opened into the building and not in the direction of egress travel. What corrective action(s) will be accomplished for those residents found to have been affected by this practice? · The facility has requested temporary waiver of the requirement for the first floor stairwell exit door near resident room #138. Waiver requested till 11/23/2023. Attached. · The facility has ordered a new door and frame to replace the first floor stairwell exit door near resident room #138. However the contractor indicated that the door and frame would need to be fabricated and that this would take between 8 and 10 weeks for parts and then an additional 3 weeks to complete the install. Attached. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

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			· All residents, visitors, and staff who would use the first floor stairwell exit door near resident room #138 have the potential to be affected by the alleged deficient practice. · The Maintenance Director performed a functional inspection of all means of egress to ensure that all facility doors in the path of egress swing in the direction of egress travel. · Audit Completed 8/18/23 all other doors in the facility in the path of egress swing in the direction of egress travel. **What measures will be put into 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 replace the first floor stairwell exit door near resident room #138. · First Floor Stairwell exit door near resident room #138 is part of the original construction of the building and facility is requesting a temporary waiver of the standard considering corrective action i.e. replacement will take more than ninety (90) days to complete. · Facility has engaged in electronic and direct in-service training with staff to increase fire safety awareness while noncompliance is being corrected.	

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			Specifically: o Relias: Fire Prevention and Response: The Basics o In Person: Means of Egress in the event of a fire: First Floor Carmel SNF. · The Executive Director/designee will complete a Life Safety CQI Egress Doors audit tool weekly to ensure doors swing in the direction of egress travel and are functioning properly. The Executive Director or designee will monitor egress doors with regular walking rounds to ensure continued compliance between weekly audits. Results of the Monitoring will be reviewed weekly and 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. **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 Egress Doors audit tool weekly to ensure doors swing in the direction of egress travel and are functioning properly. The Executive Director or designee will monitor egress doors with regular walking rounds to	

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			ensure continued compliance between weekly audits. Results of the Monitoring will be reviewed weekly and 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 Egress Doors 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 meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch			

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	solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke.	K 0363	**K 363 CORRIDOR - DOORS** Based on observation and interview, the facility failed to ensure all corridor doors had no	08/18/2023

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	This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observation and interview with the Executive Director on 08/02/23 during a facility tour the Therapy Door #1 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. The Executive Director stated that this door had recently been installed. Additionally, Therapy Door #2 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. The Executive Director stated that the door hardware was supposed to be installed last week, and that the vendor was coming today to replace the hardware. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference with the Executive Director present. This deficiency was cited on 06/13/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		impediments to closing and latching into the door frame and 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 #1 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. The Executive Director stated that this door was recently been installed. Additionally, Therapy Door #2 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. The Executive Director stated that the door hardware was supposed to be installed last week, and that the vendor was coming today to 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 been affected by this practice?** · The Executive Director oversaw installation of latching hardware by Central Indiana	

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			Hardware (CIH) on Therapy door #1 on 8/9/2023. Therapy door #1 now functions with a self-closing device and automatically latches to the door frame when closed. See Attached. · The Executive Director oversaw installation of latching hardware by Central Indiana Hardware (CIH) on Therapy door #2 on 8/9/2023. Therapy door #2 now functions with a self-closing device and automatically latches to the door frame when closed. See Attached. · The facility will ensure doors protecting corridor openings will be smoke resistive; have no impediments to closing; are self-latching and provided positive latching hardware. Ongoing, the Executive Director or designee will monitor corridor doors to ensure continued compliance. Results of 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 potential to 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. · The Maintenance Director performed an audit of all corridor	

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			doors in the Facility on or before 8/18/23, to ensure doors protecting corridor openings are smoke resistive; have no impediments to closing; are self-latching and provided positive latching hardware. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · Staff were provided in-service training on the standard in NFPA 101 Corridor – Doors specifically focusing on the requirement that corridor doors must latch and close automatically if there is a closer. · 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	

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			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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			meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results. -	