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	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	12999 N PENNSYLVANIA ST 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/15/24 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this 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 55. Quality Review completed on 08/19/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/15/24 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this Life Safety Code survey, Majestic Care of Carmel was found not in compliance with	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 REVISIT** on or after 9/3/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Seib	Executive Director	08/30/2024

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility 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 55 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/19/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and Interview, the facility failed to ensure 1 of over 5 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 10 residents. Findings include: Based on observation and interview with the Executive Director (ED) and the Maintenance Director on 08/15/24 during a facility tour between 11:45 a.m. and 1:45 p.m., the exit door into the stairwell near RR #154, equipped with a 15 second delayed egress, failed to operate as engineered. The aforementioned door had proper signage and opened freely but the magnetic locking mechanism failed to engage. When the exit door	K 0222	**K 222 EGRESS DOORS** This requirement is not met as evidenced by: 1.Based on observation and interview, the facility failed to ensure that 1 of over 5 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of the force to the release device required in 7.2.1.5.10 under all of the following condition: (a The force shall not be required to exceed 15lbf (67N). (b The force shall not be required to be continuously applied for more than 3 seconds. (c The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.. Findings include:	09/03/2024

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	was tested the magnetic locking mechanism did not function properly. The ED stated that the door would need to be fixed in order to keep residents from exiting the facility and eloping. 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, Maintenance Director, Facility Intern and Assistant Maintenance personnel present. 3.1-19(b)		Based on observation and interview with the Executive Director (ED) and Maintenance Director on 8/15/24 during a facility tour … the exit door into the stairwell near RR#154, equipped with a 15 second delayed egress, failed to operate as engineered. The aforementioned door had proper signage and opened freely but the magnetic locking mechanism failed to engage. When the exit door was tested the magnetic locking mechanism did not function properly. The ED stated that the door would need to be fixed…. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** The Maintenance Director contacted SAFECARE to address issues with the Delayed egress functions with the identified door to ensure that the delayed egress was functioning properly. Specifically Safecare addressed identified issues with the exit door into the stairwell near RR#154 to ensure that the delayed egress operated as engineered. **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	

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			staff have the potential to be affected by the alleged deficient practice The Maintenance Director with the assistance of SAFECARE performed an inspection of all egress doors to ensure that all remaining egress doors equipped with delayed egress systems in the facility are functioning properly. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** The Maintenance Director will monitor the egress doors weekly for four weeks and at least monthly thereafter as a required task added to the TELS system to ensure that all egress doors in the facility open easily and are readily accessible and are equipped with accurate signage. The Maintenance Director will monitor the egress doors equipped with delayed egress systems weekly for four weeks and at least monthly thereafter as a required task added to the TELS system to ensure that all egress doors with delayed egress systems are functioning properly. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**	

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			The Executive Director/designee will complete a Life Safety CQI audit tool daily for five days; weekly for 4 weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. 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 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 solid-bonded core wood or other material			

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	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. This deficient practice could affect 2 residents.	K 0363	**K 363 CORRIDOR - DOORS** Based on observation and interview with the Executive Director and the Maintenance director on 08/15/24 during facility	09/03/2024

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	Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 08/15/24 during a facility tour between 11:45 a.m. and 1:45 p.m., the corridor door to Resident Room # 223 failed to latch positively into the door frame. 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, Maintenance Director, Facility Intern and Assistant Maintenance personnel present. 3.1-19(b)		tour between 11:45 a.m. and 1:45 p.m., the corridor door to resident room # 223 failed to latch positively into the door frame. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** The Maintenance Director serviced the corridor door to resident room #223 to ensure that it latches positively to the door frame. **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 doors in the facility to ensure that all doors latch positively to the door frame. **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 positively to the door frame.	

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			The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above. **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 audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above. The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via	

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			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.	