CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155219	B. WING		10/17/2024	
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	•	
(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	,	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 10/17/ Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I Care of South Bend with Emergency Prometer and Mediand Suppliers, 42 C	224 20124 255219 266730 Preparedness survey, Majestic was found not in compliance eparedness Requirements for caid Participating Providers FR 483.73 The facility has 103 e time of the survey, the	E 0000	The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion see in the statement of deficiencies of any violation of regulation. To the low scope and severity these findings we respectfully request a desk review in lieur traditional revisit.	ot is et forth es, or Due of	
E 0015 SS=F Bldg	Based on record reversible to ensure emergialed to ensure emergialed to ensure emergiand procedures include provision of subsists residents, whether the place, include, but a (i) Food, water, measupplies. (ii) Alternamintain - (A) Temphealth and safety and storage of provision Fire detection, extinand (D) Sewage and	B.113(b)(6)(iii), 441.1 Is for Staff and Patients riew and interview, the facility ergency preparedness policies ude at a minimum, (1) The ence needs for staff and hey evacuate or shelter in are not limited to the following: dical, and pharmaceutical ate sources of energy to preratures to protect resident d for the safe and sanitary is; (B) Emergency lighting; (C) aguishing, and alarm systems; It waste disposal in accordance (B(b)(1). This deficient practice	E 0015	E0015 – Emergency Preparedness Policy and Procedures It is the practice of this facility ensure that a thorough Emerg Action Plan (EAP) is up-to-da and staff are educated in the that staff and/or residents nee shelter in place or evacuate of an emergency. What corrective action(s) will accomplished for those reside	gency tte, even ed to during be	

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

(X6) DATE

TITLE

Bud Johnson Executive Director 11/12/2024

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155219	B. W	ING		10/17	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	TH BEND		SOUTH	I BEND, IN 46635		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	could affect all resid	dents and staff.			found to have been affected b	y the	
					deficient practice:		
	Findings include:						
	Posed on record review and interview with the				The facility EAP policies and		
	Based on record review and interview with the				procedures were developed,		
		tor from 9:40 a.m. to 12:40 p.m. nentation of a three-day			updated, and will be maintaine the Maintenance	ea by	
		oply and an emergency menu			Director/Designee under the		
		s provided; however, no other			guidance of the Executive		
		-			Director.		
	policy, plan or procedure was provided regarding water, medical, and pharmaceutical supplies;						
	alternate sources of energy to maintain:				How other residents having th	е	
	temperatures to protect resident health and safety				potential to be affected by the		
	and for the safe and	sanitary storage of			same deficient practice will be		
	provisions; emerger	ncy lighting; fire detection,			identified and what corrective		
		alarm systems; or sewage and			action(s) will be taken:		
		ed on interview, the					
		tor stated the previous			All residents have the potentia	l to	
		had planned to review, revise			be affected by the deficient	_	
	_	ergency Preparedness Plan but			practice. Full facility updates		
	it was not complete	a.			development of the EAP polici		
	This finding was re	viewed with the Executive			procedures, and training will b reviewed by the Maintenance	е	
		enance Director at the exit			Director/Designee under the		
	conference.	chance Director at the Cart			guidance of the Executive		
					Director, monthly x 3 months,	and	
					bi-annually thereafter.		
					,		
					What measures will be put into)	
					place or what systemic change	es	
					will be made to ensure that the	€	
					deficient practice does not rec	ur:	
					The Maintenance Director, un		
					the supervision of the Executive		
					Director, will review and updat	e	
					EAP policies and procedures,		
					monthly x 3 months, and		
					bi-annually thereafter.		
			1				

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION MATE B. WING STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PROVIDERS PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	AND PLAN	OF CORRECTION					COMPLETED	
MAJESTIC CARE OF SOUTH BEND (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The			100219					
MAJESTIC CARE OF SOUTH BEND (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION (EACH DEFICIENCY) (COMPLETION DEFICIENCY) (EACH DEFICIENCY) (COMPLETION DEFICIENCY) (EACH DEFICIENCY) (AS) (COMPLETION DEFICIENCY) (COMPLETION	NAME OF F	PROVIDER OR SUPPLIEI	2					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	MAJEST	IC CARE OF SOUT	TH BEND					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The		`		P		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	IAG	REGULATORY OF	X LSC IDENTIFTING INFURMATION		IAG		ill be	DATE
quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The						` '		
put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The						1 .		
corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The						1	be	
though the facility Quality Assurance and Performance Improvement Program. The								
Assurance and Performance Improvement Program. The							ored	
Improvement Program. The						, ,		
Maintenance Director/Designee								
						Maintenance Director/Designe		
will be responsible for completing QAPI audit tool "Emergency						1	ing	
Action Plan Preparedness"						1		
monthly x 3 months and						<u> </u>		
bi-annually thereafter. If 100% compliance is not achieved an						•		
action plan will be developed.						1 · · · · · · · · · · · · · · · · · · ·		
Findings will be submitted to the							ne	
Quality Assurance and								
Performance Improvement Committee for review and								
follow-up.								
By what date the systemic						1		
changes will be completed: 11/7/2024						_		
Compliance Date: 11/7/2024						Compliance Date: 11/7/2024		
E 0032 403.748(c)(3), 416.54(c)(3), 418.113(c)(403.748(c)(3), 41	6.54(c)(3), 418.113(c)(
SS=F Primary/Alternate Means for Communication		Primary/Alternate	Means for Communication					
Bldg Based on record review and interview, the facility E 0032 E0032 – Primary and Alternate 11/07/2024	Blag	Based on record rea	view and interview, the facility	E 007	22	F0032 - Primary and Alternati	۵.	11/07/2024
failed to ensure the emergency preparedness Based on record review and interview, the facility E 0032 E0032 - Primary and Alternate 11/07/2024 Means for Communication F 0032 E0032 - Primary and Alternate 11/07/2024 Means for Communication E 0032 - Primary and Alternate 11/07/2024 Means for Communication E 0032 - Primary and Alternate 11/07/2024 Means for Communication E 0032 - Primary and Alternate E 0032 - Primary and E 0032 -			-	E 00.	32	<u>-</u>	-	11/0//2024
communication plan includes (3) Primary and		communication pla	n includes (3) Primary and					
alternate means for communicating with the It is the practice of this facility to								
following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management ensure that there are a primary and alternate means of			· · · · · · · · · · · · · · · · · · ·			-	У	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/17/2024
	PROVIDER OR SUPPLIEF		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(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 BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) E COMPLETION DATE
	_	ince with 42 CFR 483.73(c)(3). ice could affect all residents,		communication for the facility What corrective action(s) wil	l be
	Findings include:	view and interview with the		accomplished for those reside found to have been affected deficient practice:	
	Maintenance Direct on 10/17/24, the En Communication Pla of March 2024, did alternate means for interview, the Main	tor from 9:40 a.m. to 12:40 p.m. mergency Preparedness an provided with a revision date not address primary and communication. Based on ttenance Director stated the Director had planned to		Primary and Alternate mean communication will be devel updated, and maintained by Maintenance Director/Designunder the guidance of the Executive Director.	oped, the
	review, revise and u Preparedness Plan i Plan but had not co This finding was re	update the Emergency including the Communications		How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	ne pe
	conference.			All residents have the potent be affected by the deficient practice. Identification and development of the Primary Alternate means of communication, policies, procedures, and training will reviewed by the Maintenanc Director/Designee under the guidance of the Executive Director, monthly x 3 months bi-annually thereafter.	and be e s, and
				What measures will be put in place or what systemic chan will be made to ensure that the deficient practice does not reach the change of the c	ges he ecur: n or

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155219	B. W	ING		10/17/	2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			N IRONWOOD RD		
MA IEST	IC CARE OF SOUT	'H BEND			I BEND, IN 46635		
IVIAULUI		II DEND		55011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					will be conducted by the		
					Maintenance Director or Desig	gnee	
					and will include a review of eg	ress	
					doors and proper signage. Th	ie	
					Maintenance Director/Designe	ee	
					will be responsible for complet	ting	
					QAPI audit tool "Life Safety		
					Rounds" 3x/week for the first		
					month, 2x/week for the second		
					month, and weekly for at least	6	
					months.		
					How the corrective action(s) w	vill he	
					monitored to ensure the defici-		
					practice will not recur, i.e., who		
					quality assurance program wil		
					put into place:	1 50	
					pat into place.		
					Ongoing compliance with this		
					corrective action will be monitor	ored	
					though the facility Quality		
					Assurance and Performance		
					Improvement Program. The		
					Maintenance Director/Designe	ee	
					will be responsible for complet	ting	
					QAPI audit tool "Life Safety		
					Rounds" 3x/week for the first		
			1		month, 2x/week for the second	d	
					month, and weekly for at least	6	
					months. If 100% compliance i	s	
					not achieved an action plan w	ill be	
					developed. Findings will be		
					submitted to the Quality		
					Assurance and Performance		
					Improvement Committee for re	eview	
					and follow-up.		
					Dy what data the events as:		
			1		By what date the systemic		
					changes will be		
					completed: 11/7/2024		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED	
		155219	B. WING			10/17	/2024
				STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		52654	N IRONWOOD RD		
MAJEST	IC CARE OF SOU	TH BEND	SOUTH BEND, IN 46635				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	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
					Compliance Date: 11/7/2024		
E 0020	400.740(4)(0).44	C E4/4)/2) 440 442/4)/					
E 0039 SS=F	EP Testing Requ	6.54(d)(2), 418.113(d)(
Bldg	EF resulig Requ	liements					
Diag.	Based on record re	view and interview, the facility	E 00	130	E0039- Emergency Plan Testi	na	11/07/2024
	failed to conduct e	L 0037				11/0//2024	
	plan at least twice per year, including				It is the practice of this facility	to	
	_	drills using the emergency			ensure all emergency plan		
	procedures. The LTC facility must do the				exercises are completed twice	per	
	following:	,			year to include unannounced s	-	
(i) Participate in an annual full-scale exercise that is community-based; or		annual full-scale exercise that			drills using the emergency		
				procedures.			
	a. When a commun	nity-based exercise is not			l ·		
	accessible, conduc	t an annual individual,			What corrective action(s) will be	ре	
	facility-based func	tional exercise.			accomplished for those reside	nts	
	b. If the LTC facili	ty experiences an actual natural			found to have been affected by	y the	
	or man-made emer	gency that requires activation			deficient practice:		
		plan, the LTC facility is exempt					
		next required full-scale			Emergency plan exercises will		
		or individual, facility-based			conducted by the Maintenance		
		al exercise for 1 year following			Director/Designee under the		
	the onset of the act				guidance of the Executive		
	1 1	ditional exercise that may			Director.		
		limited to the following:			1		
	a. A second full-sc				How other residents having the	е	
	functional exercise	or an individual, facility-based			potential to be affected by the		
	b. A mock disaster				same deficient practice will be		
		ise or workshop that is led by a			identified and what corrective		
	_	udes a group discussion, using			action(s) will be taken:		
		ly relevant emergency scenario,			All residents have the potentia	l to	
		m statements, directed			be affected by this deficient	110	
	_	ared questions designed to			practice. The Maintenance		
	challenge an emerg				Director/Designee under the		
		TC facility's response to and			guidance of the Executive Dire	ector	
		tation of all drills, tabletop			will be responsible for complet		
		, r			zz .zzpzzizio ioi ocimpiot	···· : : : : : : : : : : : : : : : : :	1

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exercises, and emergency events, and revise the

LTC facility's emergency plan, as needed in

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emergency plan testing for the

facility at a minimum bi-annually.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		A. B	A. BUILDING COMPI		(X3) DATE : COMPL 10/17/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
	SUMMARY: (EACH DEFICIEN REGULATORY OR accordance with 42 This deficient pract: staff and visitors. Findings include: Based on record rev Maintenance Direct on 10/17/24, the fac of emergency prepa however, no docum available. Based on the Maintenance Di documentation of er training but not of er Maintenance Direct documentation of available. This finding was rev	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION CFR 483.73(d)(2). Ice could affect all residents, riew and interview with the or from 9:40 a.m. to 12:40 p.m. ility provided documentation redness training conducted; entation of exercises was record review and interview,		52654 N	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) What measures will be put int place or what systemic chang will be made to ensure that th deficient practice does not red Emergency plan exercises for facility will be conducted on or before 11/7/2024. These exercises will be conducted b Maintenance Director or Designate the guidance of the Executive Director and will ind a review of the facility's emergency plan. How the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wi put into place: Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The	oo des ecur: The the gnee clude vill be ient eat ell be	(X5) COMPLETION DATE
					Maintenance Director/Designors will be responsible for reviewing the facility's emergency action plan monthly for at least 6 months. If 100% compliance not achieved an action plan will be marked to be more achieved an action plan will be marked to be more achieved an action plan will be marked to be mar	ng 1 is	
					developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for r and follow-up.		
					By what date the systemic		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/17/2024	
	ROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635		
(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	
				changes will be completed: 11/7/2024		
K 0000				Compliance Date: 11/7/2024		
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/17/ Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C South Bend was fou Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one-story facility Type V (111) constructions and the resident rooms. 103 and had a censusurvey. All areas where the	20124 55219 66730 Code survey, Majestic Care of and not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. The facility has a fire alarm system on in the corridors, areas open hard-wired smoke detectors in The facility has a capacity of as of 68 at the time of this residents have customary ered. All areas providing	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. to the low scope and severity these findings we respectfully request a desk review in lieu of traditional revisit.	of s forth s, or Due of	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/17/2024	
	PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635	
(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
	Quality Review con	npleted on 10/21/24			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				
Diag. 01	facility failed to prokitchen exhaust systeleaning and inspected for Ventilar Protection of Commiscation 11.4 states to be inspected for greet trained, qualified, an acceptable to the aurand in accordance with Schedule for Inspected for Inspected for Inspected for Inspected for Inspected for Inspection, if the expected for Inspection for Inspection, if the expected for Inspection for I	A 96, 11.6.1 states, upon haust system is found to be deposits from grease laden nated portions of the exhaust ned by a properly trained, fied person(s) acceptable to the isdiction. Hoods, grease	K 0324	It is the practice of this facility ensure all equipment is proper installed and maintained. What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: The Maintenance Director has scheduled for SafeCare to adjust the ANSUL "Remote Pull Statis and have it remounted between in. and 48 in. above the floor height. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All staff in kitchen have the potential to be affected by this deficient practice. The Maintenance Director/Designed will be responsible for ensuring that ventilation control and fire protection of commercial cook operations inspections will be conducted and all operations in the NFPA 101, Life Safety Cook	rly De Ints Ints Ints Ints Ints Ints Ints Ints

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	ETED	
		155219	B. WI	B. WING 10/17		10/17/	/2024
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MAJECT		TH DEND			N IRONWOOD RD		
WAJEST	IC CARE OF SOUT	H BEND		5001H	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				What measures will be put into)	
					place or what systemic change	es	
		view and interview with the			will be made to ensure that the	•	
		for from 9:40 a.m. to 12:40 p.m.			deficient practice does not rec	ur:	
	on 10/17/24, photographs of the kitchen exhaust						
		ed allegedly showing the			The Maintenance Director will	be	
	1 -	eaned and inspected; however,			in-serviced on or before		
		tion was provided to show			11/2/2024. This in-service will	be	
	_	and cleaning had been			conducted by the Executive		
		n interview the Maintenance			Director and will include a revi	ew	
	Director stated he could get a copy of the				of NFPA 96, 2011 Edition,		
	documentation but failed to provide any				Standard for Ventilation Contro		
	documentation at the time of survey.				and Fire Protection of Comme		
					Cooking Operations, Section 1	11.4.	
	1	ration and interview, the					
	1	intain 1 of 1 kitchen			How the corrective action(s) w		
		m in accordance with NFPA		monitored to ensure the deficient			
	· ·	ntilation and Fire Protection of			practice will not recur, i.e., who		
		ng Operations, Section 10.5.1			quality assurance program wil	be	
		essible means for manual			put into place:		
		ocated between 42 in. and 48					
		be accessible in the event of a			Ongoing compliance with this	_	
		path of egress, and clearly			corrective action will be monito	ored	
		protected. Additionally, NFPA			though the facility Quality		
		de, 4.6.12.3 states that existing			Assurance and Performance		
		obvious to the public, if not			Improvement Program. The		
		e, shall be either maintained or			Maintenance Director/Designe		
		eient practice could affect			will bring findings to the Qualit	У	
	kitchen staff only.				Assurance and Performance		
	Findings include:				Improvement Committee for re	eview	
	Findings include:				and follow-up.		
	Rased on observation	on and interview with the			By what date the systemic		
		for from 12:41 p.m. to 3:00 p.m.			changes will be completed:		
		NSUL "Remote Pull Station"			11/11/2024		
		nches above the floor next to			Compliance Date: 11/11/2024		
		the kitchen. Based on			Compilance Date: 11/11/2024		
	I -	Sobservation, the Maintenance					
		measurement as measured with					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	5
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETI				
		155219	B. WI	NG		10/17/2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					N IRONWOOD RD		
MAJESTI	C CARE OF SOUT	H BEND		SOUTH	BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LISC IDENTIFYING INFORMATION puring discussion about the		TAG	DEFICIENCIT		DATE
		the Maintenance Director					
		g "grandfathered" because the					
		n in the location since					
	installation.						
		e reviewed with the Executive					
		enance Director at the exit					
	conference.						
	3.1-19(b)						
	3.1-17(0)						
K 0353	NFPA 101						,
SS=F	Sprinkler System -	- Maintenance and Testing					
Bldg. 01							
		view and interview, the facility	K 0.	353	K353 – Sprinkler Systems –		11/07/2024
		1 backflow prevention device			Maintenance and Testing		
		em piping was tested annually					
		NFPA 25. NFPA 25, Standard			It is the practice of this facility		
	-	Testing, and Maintenance of			maintain sprinkler systems and	t	
		rotection Systems, 2011			ensure all automatic sprinkler		
		6.2.1 states all backflow			backflow testing has been		
		in fire protection system			inspected and maintained with	all	
		d annually by conducting a			supporting documentation.		
		the system at the designed hose stream demand, where			What corrective action(a)!!! b		
		ose stations are located			What corrective action(s) will be		
	•	ose stations are located packflow preventer. This			accomplished for those resider found to have been affected by		
		ould affect all residents, staff			deficient practice:	/ uie	
	and visitors.	and anoth an residents, stair			denoient praeties.		
					The Maintenance Director had		
	Findings include:				SafeCare conduct back flow		
					prevention test on 8/20/2024		
	Based on record rev	riew and interview with the			through Work Order 164112.		
	Maintenance Direct	or from 9:40 a.m. to 12:40 p.m.			Devices in the sprinkler systen	ı	
		vas no documentation of an			were tested annually in		
	-	eventer test available for			accordance with NFPA 25,		
		t year on the backflow			Standard for the Inspection,		
		the sprinkler system water			testing, and Maintenance of		
	supply. Based on ir	nterview, the Maintenance			Water-Based Fire Protection		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155219	A. BUILDING 01 COMPLETED B. WING 10/17/2024				
		100218	D. W.			10/11/2024	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND			H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDEDIC DI AN OF CORRECTION	(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	COMPLET	ION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ould get the documentation			Systems, 2011 Edition, Section	n	
	the time of survey.	rovide any documentation at			13.6.2.1.		
	the time of survey.				How other residents having th	e	
	This finding was re	viewed with the Executive			potential to be affected by the		
		enance Director at the exit			same deficient practice will be		
	conference.				identified and what corrective		
	3.1-19(b)				action(s) will be taken:		
	17(0)				All residents and staff have th	e	
					potential to be affected by this		
					deficient practice. The		
					Maintenance Director/Designe		
					will be responsible for ensurin		
					that sprinkler system backflow prevention devices are inspec		
					at a minimum annually, with a		
					supporting documentation file		
					the life safety binder for review		
					What measures will be put into		
					place or what systemic chang		
					will be made to ensure that the		
					deficient practice does not rec	ui.	
					The Maintenance Director will	be	
					in-serviced on or before		
					11/2/2024. This in-service wil	be	
					conducted by the Executive Director and will include a revi	ew.	
					of NFPA 25, Standard for the	CVV	
					Inspection, testing, and		
					Maintenance of Water-Based	Fire	
					Protection Systems, 2011 Edi	ion,	
					Section 13.6.2.1 and best		
					documentation practices.		
					How the corrective action(s) w	ill be	
					monitored to ensure the defici		
					practice will not recur i.e. wh.	at	

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/17/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635			
(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	
K 0511 SS=E Bldg. 01	failed to ensure 1 of North pantry was pr Edition. Article 406	Electric on and interview, the facility of 1 electrical receptacle in the rotected. NFPA 70, 2011 of, Receptacle Faceplates sires receptacle faceplates shall	K 0511	quality assurance program wi put into place: Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Design will bring findings to the Quali Assurance and Performance Improvement Committee for rand follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024 K511 – Utilities – Gas and Ele It is the practice of this facility ensure all receptacles are protected in accordance with	eee tty eview 11/07/2024	
	and seat against the	completely cover the opening mounting surface. This ould affect staff in the 200 hall.		NFPA 70, 2011 Edition. What corrective action(s) will accomplished for those reside		
	Findings include: Based on observation with the Maintenance			found to have been affected be deficient practice:		
	Director from 12:41 the receptacle cover sink was missing. B	p.m. to 3:00 p.m. on 10/17/24, in the North pantry near the ased on interview at the time the Maintenance Director		The electrical outlet in the No Pantry room has had a protect cover place over it.		
	·	get a cover on the receptacle.		How other residents having the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/17/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635		
(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
	_	viewed with the Executive enance Director at the exit		same deficient practice will be identified and what corrective action(s) will be taken:	
	3.1-19(b)			All residents have the potential be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing Q/audit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second month and weekly for at least 6 mon What measures will be put intended place or what systemic change will be made to ensure that the deficient practice does not reconstructed on or before 11/2/2024. This in-service will conducted by the Executive Director and will include a reverse of NFPA 70, 2011 Edition. Art 406.6, Receptacle Faceplates (Cover Plates) and best documentation practices.	API This, this, o less le cur: I be II be iew ticle
				How the corrective action(s) we monitored to ensure the defic practice will not recur, i.e., who quality assurance program will put into place:	ient at
				Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		f '		ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
155219		155219	B. WING			10/17/	2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND		•	52654 N SOUTH	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD I BEND, IN 46635				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record rev failed to conduct qu shifts in 1 of 4 quart quarters. LSC 19.7. conducted quarterly	iew and interview, the facility arterly fire drills for 2 of 3 ters and 1 of 3 shifts in 2 1.6 requires drills to be on each shift under varied licient practice affects all	K 0	TAG	Maintenance Director/Designe will be responsible for complet QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance inot achieved an action plan wideveloped. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024 K712 – Fire Drills It is the practice of this facility ensure the fire drills are complin accordance with NFPA 101, Code 19.7.1.4 – 19.7.1.7.	ting d 6 is ill be eview to leted	11/07/2024	
	conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, there was no documentation for a first shift fire drill in the third quarter of 2024; a third shift fire drill in thesecond quarter of 2024; a third shift fire drill in third quarter of 2024; or a third shift fire drill in the fourth quarter of 2023 or				What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: The Maintenance Director/designee has conductive drills in accordance with N 101, Code 19.7.1.4 – 19.7.1.7. The Maintenance Director was	nts y the ted FPA		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/17/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR 2024. Based on reco time of record revie stated he did not have conducted during the did not state with co conducted. This finding was rev			unable to download these documents during the life saf survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring fire of are properly scheduled and documented through TELS. What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not rether the maintenance Director will in-serviced on or before	drills to ges ne cur:
				11/2/2024. This in-service w conducted by the Executive Director and will include a rev of NFPA 101, Code 19.7.1.4 19.7.1.7, and best documents practices. How the corrective action(s) monitored to ensure the defic practice will not recur, i.e., where quality assurance program w put into place: Ongoing compliance with this corrective action will be monitored to be the conductive action will be action.	view ation will be sient hat ill be

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155219 B. WING 10/17/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND. IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will bring findings to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024 K 0761 **NFPA 101** SS=F Maintenance, Inspection & Testing - Doors Bldg. 01 Based on record review and interview, the facility K 0761 K761 – Maintenance, Inspection, 11/07/2024 failed to ensure annual inspection and testing of & Testing- Doors fire door assemblies were completed in accordance with LSC 8.3.3.1. LSC 8.3.3.1 states It is the practice of this facility to openings required to have a fire protection rating ensure maintenance, inspection, by Table 8.3.4.2 shall be protected by approved, and testing of fire doors and fire listed, labeled fire door assemblies and fire door assemblies in accordance window assemblies and their accompanying with NFPA 80.5.2.1. hardware, including all frames, closing devices, anchorage, and sills in accordance with the What corrective action(s) will be requirements of NFPA 80, Standard for Fire Doors accomplished for those residents and Other Opening Protectives, except as found to have been affected by the otherwise specified in this Code. NFPA 80 5.2.1 deficient practice: states fire door assemblies shall be inspected and tested not less than annually, and a written record The Maintenance Director has of the inspection shall be signed and kept for completed testing of all fire doors inspection by the AHJ. NFPA 80, 5.2.4.1 states fire and fire door assemblies in door assemblies shall be visually inspected from accordance with NFPA 80.5.2.1.

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assembly.

both sides to assess the overall condition of door

NFPA 80, 5.2.4.2 states as a minimum, the

following items shall be verified:

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This documentation is uploaded to

How other residents having the

potential to be affected by the

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155219	B. W	B. WING 10/17/2024)24
				CTREET	ADDRESS SITY STATE TIP SOD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	10 04 DE 05 00 IT	UL DENID			N IRONWOOD RD		
MAJEST	IC CARE OF SOUT	H BEND		SOUTH	H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DI ANI OF CORRECTION		(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	TE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(1) No open holes o	or breaks exist in surfaces of			same deficient practice will be		
	either the door or fr	ame.			identified and what corrective		
	(2) Glazing, vision	light frames, and glazing beads			action(s) will be taken:		
	are intact and secur	ely fastened in place, if so					
	equipped.				All residents have the potentia	al to	
	(3) The door, frame	, hinges, hardware, and			be affected by this deficient		
	noncombustible thre	eshold are secured, aligned,			practice. The Maintenance		
	and in working orde	er with no visible signs of			Director/Designee will be		
	damage.	-			responsible for ensuring fire d	oors	
	(4) No parts are mis	ssing or broken.			and fire door assemblies are		
		do not exceed clearances			properly scheduled and		
	listed in 4.8.4 and 6	5.3.1.7.			documented through TELS.		
	(6) The self-closing	device is operational; that is,					
	the active door com	pletely closes when operated			What measures will be put into	0	
	from the full open p	oosition.	place or what systemic changes				
	(7) If a coordinator	is installed, the inactive leaf	will be made to ensure that the				
	closes before the ac	tive leaf.			deficient practice does not rec	ur:	
	(8) Latching hardwa	are operates and secures the			·		
	door when it is in th	ne closed position.			The Maintenance Director will	be	
	(9) Auxiliary hardw	vare items that interfere or			in-serviced on or before		
	prohibit operation a	re not installed on the door or			11/2/2024. This in-service wil	l be	
	frame.				conducted by the Executive		
	(10) No field modif	ications to the door assembly			Director and will include a revi	iew	
	have been performe	ed that void the label.			of NFPA 80.5.2.1 and best		
	(11) Gasketing and	edge seals, where required, are			documentation practices.		
	inspected to verify t	their presence and integrity.					
					How the corrective action(s) w	<i>i</i> ill be	
	This deficient pract	ice could affect all residents,			monitored to ensure the defici	ent	
	staff and visitors.				practice will not recur, i.e., wh	at	
					quality assurance program wil	l be	
	Findings include:				put into place:		
	Based on record rev	view and interview with the			Ongoing compliance with this		
		tor from 9:40 a.m. to 12:40 p.m.			corrective action will be monite	ored	
		cility was not able to provide			though the facility Quality		
	completed fire door	assembly inspections. Based			Assurance and Performance		
	on interview the Ma	aintenance Director			Improvement Program. The		
	acknowledged docu	mentation was not available			Maintenance Director/Designe	e	
	and wrote a list of d	locuments that he was not able			will bring findings to the Qualit	iy	
	to produce during s	urvey.			Assurance and Performance		

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11/19/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155219 B. WING 10/17/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD MAJESTIC CARE OF SOUTH BEND SOUTH BEND. IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Improvement Committee for review This finding was reviewed with the Executive and follow-up. Director and Maintenance Director at the exit conference. By what date the systemic changes will be 3.1-19(b)completed: 11/7/2024 Compliance Date: 11/7/2024 K 0914 **NFPA 101** SS=F Electrical Systems - Maintenance and Bldg. 01 Based on observation, record review and K 0914 K914 - Electrical Systems-11/07/2024 interview, the facility failed to ensure all Maintenance and Testing non-hospital-grade electrical receptacles at resident room locations were tested at least It is the practice of this facility to annually. NFPA 99, Health Care Facilities Code ensure that all non-hospital-grade 2012 Edition, Section 6.3.4.1.3 states receptacles receptacles are tested at least not listed as hospital-grade, at patient bed annually in accordance with NFPA locations and in locations where deep sedation or 99, Health Care Facilities Code general anesthesia is administered, shall be tested 2012 Edition, Section 6.3.4.1.3 at intervals not exceeding 12 months. and Section 6.3.3.2. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical What corrective action(s) will be integrity of each receptacle shall be confirmed by accomplished for those residents visual inspection. The continuity of the found to have been affected by the grounding circuit in each electrical receptacle shall deficient practice: be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be The maintenance confirmed; and retention force of the grounding director/designee will ensure that blade of each electrical receptacle (except all non-hospital-grade receptacles locking-type receptacles) shall be not less than are tested at least annually in 115 grams (4 ounces). This deficient practice accordance with NFPA 99, Health could affect all residents, staff and visitors. Care Facilities Code 2012 Edition,

Findings include:

Based on record review and interview with the Maintenance Director from 9:40 a.m. to 12:40 p.m. on 10/17/24, the facility was not able to provide documentation of annual testing of electrical

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Section 6.3.4.1.3 and Section

TELS. All non-hospital grade

receptacles will be tested no later

6.3.3.2, and ensure that documentation is uploaded to

than 11/7/2024.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/17/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635					
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE		
	Maintenance Directon 10/17/24, non-hreceptacles were in throughout the faci Maintenance Directocumentation and documentation. This finding was re	on observation with the tor from 12:41 p.m. to 3:00 p.m ospital-grade electrical use in all resident rooms lity. Based on interview, the tor acknowledged the missing wrote a list of missing viewed with the Executive enance Director at the exit		How other residents having potential to be affected by same deficient practice will identified and what correct action(s) will be taken: All residents have the pote be affected by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring all non-hospital-grade receptatested and properly scheduled/documented the TELS. What measures will be put place or what systemic chawill be made to ensure that deficient practice does not The Maintenance Director in-serviced on or before 11/2/2024. This in-service conducted by the Executiv Director and will include a of NFPA 99, Health Care FC Code 2012 Edition, Section 6.3.4.1.3 and Section 6.3.5 best documentation practice. How the corrective action(monitored to ensure the depractice will not recur, i.e., quality assurance program put into place: Ongoing compliance with the corrective action will be monitored to ensure the depractice will not recur, i.e., quality assurance program put into place: Ongoing compliance with the corrective action will be monitored to ensure the depractice will not recur, i.e., quality assurance program put into place: Ongoing compliance with the corrective action will be monitored to ensure the depractice will not recur, i.e., quality assurance program put into place: Ongoing compliance with the corrective action will be monitored to ensure the depractice will not recur, i.e., quality assurance program put into place: Ongoing compliance with the corrective action will be monitored to ensure the depractice will not recur, i.e., quality assurance program put into place:	the I be ive sential to ential to en		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		r í	JILDING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/17/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND				52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD H BEND, IN 46635		
(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)	ATE	(X5) COMPLETION DATE
K 0920 SS=D Bldg. 01	Extens Based on observatifailed to ensure 1 of as a substitute for for Edition, 400.8 states 400.7 flexible cord for (1) as a substitute deficient practice of 203. Findings include: Based on observatiful Maintenance Director on 10/17/24, an extension of the subservation of the subser	ent - Power Cords and on and interview, the facility f 1 flexible cords were not used ixed wiring. NFPA-70 2011 c unless specifically permitted in s and cables shall not be used tte for fixed wiring. This ould affect 1 resident in room on and interview with the tor from 12:41 p.m. to 3:00 p.m. tension cord was being used in to provide power to a phone	K 0	920	Improvement Program. The Maintenance Director/Designe will bring findings to the Qualit Assurance and Performance Improvement Committee for mand follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024 K920 – Electrical Equipment-Power Cords and Extension Could be strips are not used as a substitute for fixed wiring to provide power equipment. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice:	cords to ower itute ver to be ents by the	11/07/2024

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observation.

conference.

3.1-19(b)

charger. Based on observation and interview the

Maintenance Director acknowledged the

extension cord and removed it at the time of

This finding was reviewed with the Executive

Director and Maintenance Director at the exit

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source.

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was removed and the device was

plugged into an appropriate power

How other residents having the

potential to be affected by the

same deficient practice will be

identified and what corrective action(s) will be taken:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155219	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/17/2024	
	ROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD 1 BEND, IN 46635		
(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	
IAU	REGULATORY OF	A LOC IDENTIFITING INFORMATION	IAG	All residents have the potential be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month which will include checks for various rooms and office to er compliance with extension contained and power strips. What measures will be put introluce or what systemic change will be made to ensure that the deficient practice does not recompliance by the Maintenance Director or Designant will include a review of extension cords and power strusage. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month of the corrective action (s) we monitored to ensure the deficient practice will not recur, i.e., which quality assurance program will put into place:	API " " " " " " " " " " " " " " " " " " "	

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Ongoing compliance with this

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155219		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/17/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP COD 52654 N IRONWOOD RD SOUTH BEND, IN 46635				
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					corrective action will be monitor though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designe will be responsible for complet QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance inot achieved an action plan wideveloped. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up. By what date the systemic changes will be completed: 11/7/2024 Compliance Date: 11/7/2024	e ing 1 6 s II be	

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