STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING -- B. WING	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

(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: 06/24/24 Facility Number: 000477 Provider Number: 155570 AIM Number: 100290860 At this Emergency Preparedness survey, Majestic Care of McCordsville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 48 certified beds. At the time of the survey, the census was 30. Quality Review completed on 06/27/24	E 0000	We respectfully request that this plan of correction be considered for a desk review in lieu of a post survey revisit. Thank you.	
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: 06/24/24 Facility Number: 000477 Provider Number: 155570 AIM Number: 100290860 At this Life Safety Code survey, Majestic Care of McCordsville was found not in compliance with	K 0000	We respectfully request that this plan of correction be considered for a desk review in lieu of a post survey revisit. Thank you.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Collins	HFA	07/18/2024

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 with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in resident Room 22. The facility has battery operated smoke detectors in 20 of 21 resident sleeping rooms. The facility has a capacity of 48 and had a census of 30 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has an unsprinklered, detached 2 story wood frame pole barn housing a sprinkler system water storage tank and fire pump; an unsprinklered, detached 2 car garage used for oxygen storage; and an unsprinklered, 2 story wood barn used for housing a lawn mower and tractor and a snow blower. Quality Review completed on 06/27/24			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number			

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	of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation and interview; the facility failed to ensure the building construction type for the two-story portion of the facility was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 prohibits a two story sprinklered building to be of Type V(000) construction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0161	**It is the responsibility of the facility to ensure that the building construction type for the two-story portion of the facility is permitted.** **The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents**	07/12/2024

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	Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director on 06/24/24 between 1:05 p.m. and 2:20 p.m., the two-story portion of this fully sprinklered building had exposed wood as the structural element for the exterior load bearing wall and an interior load bearing wall in the sprinkler riser room in the basement. In addition, the top portion of the stairwell wall in the attic had exposed wood with one half inch thick plaster covering the interior portion of the stairwell wall. Residents have customary access to the dining room and the therapy room on the first floor of the two-story portion of the facility. Based on interview at the time of record review and of the observations, the Executive Director stated the second floor has been totally vacated of staff offices and storage and would be utilizing a Fire Safety Evaluation System (FSES) to show compliance to the Life Safety Code (LSC). This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**affected.How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on record review, observation and interview, the facility failed to ensure 1 of 1 stairway enclosure door was secured against	K 0225	**It is the responsibility of the facility to ensure that stairway enclosure door is locked at all**	07/12/2024

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	unauthorized access for the purpose of the FSES. This deficient practice affects 15 including staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director on 06/24/24 at 1:10 p.m., the 90 minute rated stairwell door going into the second floor was unlocked. Based on record review of a Fire Safety Evaluation System (FSES) dated 06/09/23, the second to last paragraph on page one states, 'If both spaces, however, zones 6 and 7 are abandoned and then entirely emptied of all storage items and offices plus the spaces made inaccessible by having the doors to the stairs locked, the zones could be ignored for the purposes of the FSES'. Per the FSES, zone 6 is the second floor with no certified beds and no resident access, offices, or storage. Zone 7 is attic space, with no resident access and only storage. Based on observation with the Executive Director, the second floor and attic have been totally vacated of all storage and office space. The Executive Director confirmed the stairwell door to the second floor was unlocked and not secured against unauthorized access at the time of the survey. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference.		**times. A deadbolt lock was placed on the door with a limited number of keys given out.** **The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. A deadbolt lock was placed on the door to ensure the door remains locked. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: A deadbolt lock was placed on the door with a limited number of keys given out to ensure it remains locked. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or designee will audit the door weekly to ensure it is locked. All findings will be reported to the monthly QAPI meeting.**	

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K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to maintain the required corridor width throughout the facility. LSC 19.2.3.4* states any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as a means of egress. This deficient practice could affect at least seven residents and staff using the dining room. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and Executive Director on 06/24/24 between 1:05 p.m. and 2:20 p.m., the ramp and adjacent stairs by Room 22 measured 35 inches (ramp) and 33 inches (steps) in width. Additionally, the aforementioned ramp which is approximately 15-20 feet in length, did not appear to meet the overall slope requirement for existing facilities which is 1 inch of fall for every 6 inches of rise. Based on interview with the Executive Director, she stated Room 22 is no longer a resident room and is now office space. The Executive Director stated residents use the dining room in the house portion of the facility at the top of the ramp /stairs that measure less than 48 inches in clear width. This finding was reviewed with the Executive	K 0232	**It is the responsibility of the facility to ensure that the building construction type for the two-story portion of the facility is permitted.** **The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents affected.How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure we meet requirements.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is**	07/12/2024

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	Director and Maintenance Director at the exit conference. 3.1-19(b)		**permitted. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.**	
K 0241 SS=E Bldg. 01	NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 Based on observation and interview, the facility failed to provide the required number of exits from the basement area. LSC 19.2.4.4 states that not less than two exits shall be accessible from each smoke compartment, and egress shall be permitted through an adjacent compartment(s), provided that the two required egress paths are arranged so that both do not pass through the same adjacent smoke compartment. This deficient practice could affect up to 5 staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 06/24/24 between 1:05 p.m. and 2:20 p.m., in the basement only one means of egress	K 0241	**It is the responsibility of the facility to ensure that the building construction type for the two-story portion of the facility is permitted and the amount of exits from the basement area. The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents affected.How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be**	07/12/2024

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	was provided. There appeared to be only one way into and one way out of the basement area. Based on interview with the Executive Director, she stated a Fire Safety Evaluation System (FSES) would be utilitzed to show equivalency to the Life Safety Code (LSC). This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		**taken. All residents have the potential to be affected but none were identified. An FSES evaluation was conducted to ensure the facility construction type is permitted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: An FSES evaluation was conducted to ensure the facility receives a passing score and the construction type is permitted. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The ED will assure that the second floor is abandoned and remains out of use. We will continue to monitor and bring to QAPI monthly.**	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer			

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	patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect at least two staff in the kitchen. Findings include: Based on record review from 10:20 a.m. to 1:05 p.m. with the Maintenance Director on 06/24/24, there was documentation dated 07/31/2023 stating 'Trip Test Passed' of an installed kitched fire suppresssion system. A semiannual kitchen fire suppression system inspection six months after was not available for review. Based on interview at the time of record review, the Maintenance Director stated a fire suppression system had been installed in the kitchen before he started at	K 0324	**It is the responsibility of the facility to ensure that the kitchen fire suppression system is inspected semiannually. The kitchen fire suppression system was inspected on 7/10/2024. The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. The kitchen fire suppression system was inspected on 7/10/2024.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The kitchen fire suppression system was inspected by Safecare on 7/10/2024. The fire suppression**	07/12/2024

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	the facility in September 2023, and has been trying to schedule a vendor to perform the inspection of the suppression system. The Maintenance Director confiirmed a semiannual kitchen fire suppression system inspection has not been conducted since 07/31/2023. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**system will be inspected by an outside agency every 6 months.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or designee will audit the kitchen fire suppression system inspections monthly x 6 to ensure inspections are up to date. Will reference TELS for monitoring. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting. Executive Director to monitor.**	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 17 portable fire extinguishers had pressure gauge readings in the acceptable range in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2 requires periodic inspection of fire extinguishers shall include pressure gauge reading or indicator in the operable range or position. When an inspection of any rechargeable dry chemical fire extinguisher reveals a deficiency in Section 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable	K 0355	**It is the responsibility of the facility to ensure that the portable fire extinguishers have pressure gauge readings in the acceptable range in accordance with NFPA 10. The portable fire extinguisher was replaced with a correctly charged extinguisher. The corrective action taken for those residents found to be affected by the deficient**	07/12/2024

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	maintenance procedures. This deficient practice could affect over 2 staff in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 2:05 p.m. on 06/24/24, the pressure gauge on the mounted K Class type fire extinguisher in the kitchen showed the extinguisher was overcharged. The portable fire extinguisher inspection contractor had an affixed maintenance tag indicating the annual maintenance for the fire extinguisher was performed in March 2024. The affixed maintenance tag also indicated monthly inspections by facility staff had been documented through May of 2024. Based on interview at the time of the observation, the Maintenance Director agreed the pressure gauge on the portable fire extinguisher in the kitchen indicated the fire extinguisher was overcharged. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**practice includes: There are no identified residents How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. The portable fire extinguisher was replaced with a correctly charged extinguisher.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The portable fire extinguisher was replaced with a correctly charged extinguisher. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or designee will audit the portable fire extinguishers monthly x 6 months to ensure the pressure gauge readings are in the acceptable range in accordance with NFPA 10. An audit will be completed after the yearly service to confirm all units are charged properly. All negative findings will be immediately remedied. All findings will be brought to the monthly QA meeting. Executive**	

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			Director to monitor.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all ground fault circuit interrupter (GFCI) outlets were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect at least two residents and staff. Findings include: Based on observation with the Maintenance Director and Executive Director on 06/24/24 at 1:50 p.m., when the ground fault circuit interrupter (GFCI) receptacle located within two feet from a sink in the clean utility room was tested with a GFCI tester, the electric receptacle did not trip. Based on interview at the time of observation, the Maintenance Director confirmed the GFCI electric receptacle within two feet of the sink in clean utility did not trip when tested. Additionally, a GFCI receptacle at the bathroom sink in resident 7 indicated 'Hot/Neutral Reverse' when tested with a GFCI tester. This was confirmed by the Maintenance Director at the time of observation.	K 0511	**It is the policy for the protection of residents that the facility ensure that GFCI outlets was properly maintained for protection against of electric shock. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. 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?The GFCI in the clean utility room and resident room 7 was replaced and is functioning correctly. All GFCI outlets were tested and work properly.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?The**	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155570	A. BUILDING 01 B. WING	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF MCCORDSVILLE	7476 W LANE RD MCCORDSVILLE, IN 46055

(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
	These findings were reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**GFCI in the clean utility room and resident room number 7 was replaced and is functioning correctly. All GFCI outlets were tested and work properly.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?The maintenance director and/or designee will do monthly audits x6 months. All negative findings will be immediately remedied and brought to the ED's attention. The quality assurance performance improvement committee (QAPI) will review the audits for six (6) months. The QAPI committee may opt to discontinue review of audit during QAPI meetings if compliance is evident.**	