STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. BUILDING -- B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF BEDFORD	2111 NORTON LN BEDFORD, IN 47421

(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: 07/10/23 Facility Number: 000040 Provider Number: 155100 AIM Number: 100274460 At this Emergency Preparedness survey, Majestic Care of Bedford was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 190 certified beds. At the time of the survey, the census was 91. Quality Review completed on 07/12/23	E 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during a Life Safety Survey with exit on 07/10/23. Please accept this Plan of Correction as the provider's credible allegation of compliance as of July 26, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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: 07/10/23 Facility Number: 000040 Provider Number: 155100 AIM Number: 100274460 At this Life Safety Code survey, Majestic Care of Bedford was found not in compliance with	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during a Life Safety Survey with exit on 07/10/23. Please accept this Plan of Correction as the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Marlow	Administrator	07/26/2023

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

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	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 split level facility with each of the two floors exiting at ground level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on both levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke alarms installed in all resident sleeping rooms. The facility has a capacity of 190 and had a census of 91 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage building. Quality Review completed on 07/12/23		provider's credible allegation of compliance as of July 26, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the Unit Five dining room. This deficient practice could affect staff and 20 residents in the vicinity of Unit Five dining room. Findings include: Based on observation with the Administrator and Maintenance Director on 07/10/23 at 1:25 p.m. during a tour of the facility, the Dining room in Unit Five contained a hot oil popcorn popper. The hot oil popcorn popper was plugged in and operating at the time of observation. The two corridor doors to the dining room of Unit Five did not have self-closing devices or hinges installed. Based on interview at the time of observation, the Maintenance Director confirmed the corridor doors of the dining room were not equipped with self-closing devices or hinges where the hot oil	K 0321	**It is the responsibility of the facility to maintain the hot oil popcorn popper.** **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.** The 20 residents on unit five have the potential to be affected but none were identified. **What measures will be put into place and what systemic changes will be made to**	07/10/2023

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	popcorn popper was in use. The Maintenance Director unplugged the hot oil popcorn popper at the time of observation. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur:** The maintenance director and activity director were reeducated on the location of the hot oil popcorn maker in relation to fire doors. The popcorn maker will only be in operation behind self closing fire doors. **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 bldg monthly for 6 months to assure that when hot oil popcorn maker is in use it is behind self closing fire doors. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.	
K 0363 SS=D 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 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			

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	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 1 of over 100 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. Findings include:	K 0363	It is the responsibility of the facility to ensure that corridor doors have no impediment to closing and latching into the door frame and will resist the passage of smoke. **The corrective action taken for those residents found to be affected by the deficient practice includes:**	07/24/2023

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	Based on observation with the Administrator and Maintenance Director on 07/10/23 at 2:02 p.m. during a tour of the facility, the corridor door to Resident Room 115 failed to close and latch positively into the door frame. Based on interview at the time of observation, the Maintenance Director confirmed the resident room door did not latch into the door frame. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		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. Room 115 door was maintained and closes and latches positively into the door frame. All other doors were audited and maintained as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Full audit of all corridor doors in the facility were observed, doors that needed to be adjusted were to assure they fully latched into the door frames. **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 tour bldg monthly for 6 months to assure rooms that doors latch positively into the door frames. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.	

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