STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155376	A. BUILDING -- B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

(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: 04/18/24 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170 At this Emergency Preparedness survey, Majestic Care of Sheridan was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 77. Quality Review completed on 04/22/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lauren Kirkwood	HFA, RN	05/18/2024

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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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review, observation and interview, the following was noted: a. Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Exercise generator (with no load)" with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, weekly emergency generator inspection documentation from 05/30/23 through 02/13/24 and from 02/27/24 through 04/16/24 was not available for review. Based on interview during the exit conference from 3:05 p.m. to 4:10 p.m. on 04/18/24, the Administrator agreed weekly emergency generator inspection documentation for the aforementioned weekly periods was not available for review. b. Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator Under Load" with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m.	E 0041	1. Emergency power system inspection, testing and maintenance requirements have been implemented. 2. The weekly inspection and monthly load testing has been completed. Emergency Stop Button was installed exterior to the generator. 3. The Maintenance Director was educated to conduct weekly inspections and monthly load testing by the Executive Director. 4. This will be reviewed by the Executive Director/designee upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	on 04/18/24, load testing documentation for the eleven month period of May 2023 through March 2024 was not available for review. Based on interview during the exit conference from 3:05 p.m. to 4:10 p.m. on 04/18/24, the Administrator agreed load testing documentation for the eleven month period of May 2023 through March 2024 was not available for review. c. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the emergency generator was not equipped with a remote emergency stop button. The emergency generator for the facility is located outside the building in a weather proof shell on the south side of the property. An emergency stop button was located on the generator inside the weather proof shell but a remote emergency stop could not be located on the exterior of the weather proof shell or at any other interior or exterior location on the premises. Manufacturer's documentation affixed to the diesel fired generator indicated it was manufactured in April 2012 and was rated at 60 kW. Based on interview at the time of observation, the Maintenance Director agreed a remote emergency stop for the emergency generator could not be located. These findings were reviewed with the Administrator during the exit conference.			
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).	K 0000		

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	Survey Date: 04/18/24 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170 At this Life Safety Code survey, Majestic Care of Sheridan was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 77 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services which were not sprinklered. Quality Review completed on 04/22/24			
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			

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	Construction Type 1 I (442), I (332), II (222) Any number 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 observation and interview, the facility failed to maintain the building construction type for Type V(111) construction in 1 of 1 automatic transfer switch rooms. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0161	1. The 2 inch diameter hole noted in the wall above the electrical panel in the main electrical room for the facility has been repaired with at least a 1 hour fire-resistance rating. 2. No other holes were identified. 3. The Maintenance Director was	05/19/2024

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	Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, a two inch in diameter hole was noted in the wall above the electrical panel identified as "Emergency Power" in the main electrical room for the facility. The hole went through the wall of the adjoining automatic transfer switch room as well with a two inch in diameter hole noted in the wall of the automatic transfer switch room. Two layers of 5/8th's inch thick drywall was installed on each side of the exposed wood wall stud for the rooms. Based on interview at the time of the observations, the Maintenance Director agreed the hole exposing the wall stud did not maintain the building construction type. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		educated on by the Executive Director on 4/19/24 about repairing any holes near electrical panels immediately. 4. Routine walking rounds will be reviewed by the Executive Director/designee upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges were continuously maintained free of obstruction to full use in case of emergency. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the main dining room.	K 0211	1. Pea gravel and rock were removed. An additional sidewalk and gate will be added for proper egress by 5/19/24. Porch swing will not block new path of egress. 2. No other egress were found to be deficient.	05/19/2024

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the exit door to the outside of the facility in the main dining room was marked as a facility exit door with an exit sign. The exit discharge for the main dining room exit is onto a concrete porch and then to a gated courtyard. The gate for the courtyard exit is at the north end of the porch immediately adjacent to the porch. A porch swing which was mounted on the porch ceiling blocks the path of egress to the adjacent courtyard gate. If residents in wheelchairs or multiple residents tried to egress in the path of the exit discharge to the adjacent courtyard gate, the porch swing would have to be swung out of the way or residents would have to go off the porch onto the grass to reach the courtyard gate. The courtyard gate was not locked. The exit discharge outside the courtyard gate had one pile of pea gravel on the ground and a separate rock pile on the ground each partially blocking the path to the public way from the courtyard gate. Based on interview at the time of the observations, the Maintenance Director stated the pea gravel pile and rock pile were in the exit discharge due to recent building repair work and agreed the porch swing had to be swung out of the way in order to use the main dining exit discharge to the public way. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		3. The Maintenance Director was educated by Executive Director to ensure clear egress maintained at all times with monthly fire drills. 4. This will be reviewed by the Executive Director/designee upon completion, and TELS will be reviewed monthly for completion of assigned audits. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	
K 0271 SS=E	NFPA 101 Discharge from Exits			

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Bldg. 01	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharge walking surfaces were nominally level and did not have abrupt changes in elevation. LSC 7.1.6.2 states abrupt changes in elevation of walking surfaces shall not exceed 1/4 inches. Changes in elevation exceeding 1/4 inches, but not exceeding 1/2 inches, shall be beveled with a slope of 1 in 2. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the main dining room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the exit door to the outside of the facility in the main dining room was marked as a facility exit door with an exit sign. The exit discharge for the main dining room exit is onto a concrete porch and then to a gated courtyard. The gate for the courtyard exit is at the north end of the porch immediately adjacent to the porch. The concrete surface at the courtyard gate at the meeting edge of the north end of the porch is a separate section of concrete than the concrete porch. The meeting edge of the north end of the concrete porch is one and one half inches higher than the concrete surface at the courtyard gate. Based on interview at the time of the observations, the Maintenance Director agreed	K 0271	1. Identified unlevel concrete will be fixed by 5/19/2024. 2. No other egress were found to be deficient. 3. The Maintenance Director was educated by Executive Director to ensure clear egress maintained at all times with monthly fire drills. 4. This will be reviewed by the Executive Director/designee upon completion, and TELS will be reviewed monthly for completion of assigned audits. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	the meeting edge of the north end of the porch was one and one half inches higher than the concrete pad in front of the courtyard gate with the two separate sections of concrete not nominally level with an abrupt change in elevation. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure egress lighting for 1 of 8 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the 100 Hall by Room 101. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the exit discharge for the 100 Hall by Room 101 was equipped with two	K 0281	1. Bird's nest was removed. Light was no longer obscured. 2. No other lights were identified with concerns. 3. The Maintenance Director was educated by the Executive Director that exit lights should be functioning and not obscured at all times. 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	separate lighting fixtures each with one light bulb but a bird's nest filled the entire inside of the north lighting fixture and obscured the light from the bulb which was illuminated at the time of the observations. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit discharge was not arranged with the minimum number of operable lighting fixtures due to the bird's nest inside the north lighting fixture. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document monthly testing for 2 of 2 battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.	K 0291	1. Monthly documentation for battery backup lights has been completed. 2. No other lights were affected. 3. The Maintenance Director was educated by the Executive Director that backup lights must be check and documented monthly for proper functioning. 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	(4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Emergency & Exit Lighting: Conduct a 30 second functional test" documentation with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, monthly battery operated light testing documentation for the nine month period of July 2023 through March 2024 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, one battery operated light was noted in the main electrical room and one battery operated light was noted in the automatic transfer switch room. Each battery light location operated when its respective test button was pushed. Based on interview during the exit conference from 3:05 p.m. to 4:10 p.m. on 04/18/24, the Administrator agreed monthly battery operated light testing documentation for the nine month period of July 2023 through March 2024 was not available for review at the time of the survey. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			

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	155376	A. BUILDING 01 B. WING	04/18/2024

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors installed in 40 of 40 resident sleeping rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Battery-Operated Smoke Detector Maintenance Log" with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, resident sleeping room smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the	K 0300	1. Documentation for annual smoke detector inspection was completed. 2. All residents have potential to be affected. 3. The Maintenance Director was educated by the Executive Director that annual inspection of smoke detector will be check and documented monthly for proper functioning. 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	facility has battery operated smoke detectors installed in all resident sleeping rooms. The Maintenance Director stated the facility cleaned the detectors when they recently replaced the batteries but agreed resident sleeping room smoke detector cleaning documentation within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, all resident sleeping room smoke detectors are battery operated. Manufacturer's documentation affixed to the Kidde Model i9050 smoke detector installed on the wall above the corridor door inside resident sleeping Room 213 stated "clean the detector annually". Manufacturer's documentation affixed to the Kidde Model i9040 smoke detector installed on the wall above the corridor door in resident sleeping Room 217 also stated "clean the detector annually". Based on interview at the time of the observations, the Maintenance Director stated each resident sleeping room has either model battery smoke detector installed in the room. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
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			

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	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 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 range hood fire suppression systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood fire suppression system inspection contractor's "Invoice" documentation dated 04/05/24 with the	K 0324	1. Kitchen range hood fire supression system is now in working order. 2. All residents have potential to be affected. 3. The Maintenance Director was educated by the Executive Director that hood fire suppression should always be in working order. 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, deficiencies were noted with the kitchen range hood fire suppression system fire extinguishing equipment. The "Description" section of the 04/05/24 "Invoice" stated "performed semi-annual hood suppression inspection on 04/04/24. Electrical appliances did not shut down. Customer wants a quote to have electrical fixed". Based on interview at the time of record review, the Maintenance Director stated he was not aware of any deficiencies with the kitchen range hood suppression system because he just started working at the facility within the last two weeks. The Maintenance Director contacted the kitchen range hood fire suppression system inspection contractor at the time of the survey who relayed to the facility that the electrical appliances under the kitchen range hood do not always shut down when tested to shut down. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, one electric steamer appliance and one electric convection oven appliance were installed under the kitchen range hood. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review, observation and interview, the following was noted:	K 0353	1. Tamper switch was installed. Sections of pipe that were found to be rusted and leaking during 3 year inspection leak test were replaced. Another leak test was performed after repairs. Sprinkler that was corroded was replaced with a new sprinkler. 2. All residents have potential to be affected. 3. The Maintenance Director was educated by the Executive Director that tamper switch shall be installed and functioning properly at all times. MD was also educated by ED that any findings on 3 year leak test should be repaired in an emergent time frame and weekly dryer sprinkler gauge checks/annual in-house visual inspections, monthly fire sprinkler system in-house inspections all must be completed on time. 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire	05/19/2024

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	a. Based on review of the sprinkler system inspection contractor's "Work Performed" documentation dated 05/15/23 with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, the facility's dry sprinkler system does not have a tamper switch. The "Description" section of the 05/15/23 documentation stated "Noticed system did not have tamper switch on main control valve. Recommended to maintenance they install tamper switch. Send quote to install tamper switch". Based on interview at the time of record review, the Maintenance Director stated he did not know if a tamper switch had been installed on the main control valve because he just started working at the facility within the last two weeks. b. Based on review of the sprinkler system inspection contractor's "Work Performed" documentation dated 04/01/24 with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, the facility's dry sprinkler system failed its 3 year leak test. The "Description" section of the 04/01/24 documentation stated "Performed 3 year leak test on dry system. System failed first test. Send quote to replace 14 feet of 1.5 inch (piping) leaking at the threads above Room 206, also send quote to replace 10 feet of 4 inch (piping) above room 207 then perform leak test". Review of the sprinkler system inspection contractor's "Quote # q45456" documentation dated 04/03/24 indicated work to replace the piping and conduct the three year leak test had been approved by the facility on 04/03/24. Based on interview at the time of record review, the Administrator stated the work has not yet been performed as the contractor is awaiting parts.		drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	c. Based on review of the sprinkler system inspection contractor's "Work Performed" documentation dated 04/01/24 with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, the fire department connection drain for the facility's dry sprinkler system is leaking. The "Description" section of the 04/01/24 documentation stated "Upon arrival, noticed water leaking out of fdc drain line. Removed check valve and inspected interior. Did not find any rust or debris blocking check from closing. During 5 year fdc hydro test, noticed check valve was allowing water fill system side and building pressure, which was another indicator that the check valve was leaking. After test, turned check back around and reset system. Found fdc line continuing to leak. Send quote to replace 4 inch 300 FM 706 check valve". Review of the sprinkler system inspection contractor's "Quote # q45454" documentation dated 04/03/24 indicated work to replace the failed fire department check valve and perform 5 year hydrostatic test for new and remaining piping had been approved by the facility on 04/03/24. Based on interview at the time of record review, the Administrator stated the work has not yet been performed as the contractor is awaiting parts. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the main control valve for the facility's dry sprinkler system was not locked, sealed or supervised. In addition, the fire department connection drain line was leaking water. These findings were reviewed with the Administrator during the exit conference.			

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	3.1-19(b) 2. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of Direct Supply TELS documentation with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, weekly sprinkler gauge inspection documentation for 44 weeks of the most recent 52 week period was not available for review. In addition, weekly inspection documentation for all sprinkler system control valves for 44 weeks of the most recent 52 week period was also not available for review. The most recent documented sprinkler system gauge and control valve inspections done by the facility was on 06/13/23. Based on interview			

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	during the exit conference from 3:05 p.m. to 4:10 p.m. on 04/18/24, the Administrator agreed weekly sprinkler gauge and control valve inspection documentation for 44 weeks of the most recent 52 week period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the facility has one dry sprinkler system and had three pressure gauges. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were not painted in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.			

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	155376	A. BUILDING 01 B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the soiled utility room by the 200 Hall corridor door set. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the sprinkler located on the ceiling in the soiled utility room by the 200 Hall corridor door set was green with corrosion. Based on interview at the time of the observations, the Maintenance Director stated the sprinkler is scheduled to be replaced and agreed the aforementioned automatic sprinkler location was green with corrosion. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected	K 0712	1. Fire drills will be completed under varying conditions on	05/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155376	A. BUILDING 01 B. WING	04/18/2024

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	times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Fire Drills" documentation with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, four of six second shift fire drills conducted within the most recent twelve month period on 06/19/23, 07/12/23, 10/27/23 and on 02/01/24 were conducted at, respectively, 4:00 p.m., 4:00 p.m., 3:00 p.m. and 4:00 p.m. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) and 3.1-51(c)		second shift. 2. No other drills were affected. 3. The Maintenance Director was educated by the Executive Director that fire drills must be completed under varying conditions and times. . 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	
K 0751 SS=E Bldg. 01	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does			

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	155376	A. BUILDING 01 B. WING	04/18/2024

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MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

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	not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 Based on observation and interview; the facility failed to provide flame propagation documentation for curtains installed in one of one main dining rooms open to the corridor. Section 10.3.1 states draperies, curtains, and other loosely hanging furnishings and decorations shall meet the flame propagation performance criteria in NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect over 20 residents, staff and visitors in the main dining room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, flame propagation documentation was not affixed to any of the curtains installed on all windows in the main dining room which was open to the corridor. Each of the curtains extended from nearly the ceiling to the floor of the room which would exceed 20% of the aggregate area of the wall on which they were located. Based on interview at the time of the observations, the Maintenance Director stated he was not aware if the curtains had been treated with fire retardant material and agreed flame propagation documentation for the curtains was not available for review. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0751	1. All draperies and curtains that were identified, have now been sprayed to meet regulation. A log is now being maintained. 2. No other drills were affected. 3. The Maintenance Director was educated by the Executive Director that curtains that are not flame retardant must be sprayed with flame propagation and documented/logged according to manufacturer's instructions. 4. This will be reviewed by the Executive Director/designee upon completion and with monthly fire drills. This information with be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024
K 0753 SS=E	NFPA 101 Combustible Decorations			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155376	A. BUILDING 01 B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

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Bldg. 01	Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 40 corridor doors to resident sleeping rooms was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4) *The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in	K 0753	1.The identifiable decoration was treated with flame retardant spray and documented. 2. No other doors were affected. 3. The Maintenance Director educated about items that needed treated and documented that they have been sprayed with retardant spray. 4. The Executive Director/designee upon completion will ensure done and documented with monthly fire drills. This information will be sent to QAPI for trending and completion follow-up. 5. 5/19/2024	05/19/2024

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5) *They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 117. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, a large blue and white circular plastic wreath was affixed to the corridor door to resident sleeping Room 117 and covered nearly 50% of face of the corridor side of the door. The plastic wreath did not have affixed documentation indicating the material was fire			

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	retardant or fire retardant treated. Based on interview at the time of the observations, the Maintenance Director stated he was not aware if the plastic wreath had been treated with fire retardant material and agreed fire retardant documentation for the plastic wreath was not available for review. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure the annual inspection and testing of all fire door assemblies was completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.	K 0761	1. Annual inspections and testing of all fire door will be completed. South door in corridor mentioned that failed to fully self-close and latch into door frame was repaired. 2. No other doors were affected. 3. The Maintenance Director will be educated by the Executive Director that annual inspections and testing of all fire doors must be completed timely. MD was also educated that if a defect was found during testing/inspection, that it must be fixed immediately. Annual inspection and testing of all fire doors will be completed monthly x 3 months. 4. The Executive Director/designee upon completion will ensure done and documented with monthly fire drills. This information will be sent to QAPI for trending and completion	05/19/2024

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	155376	A. BUILDING 01 B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 40 residents, staff and visitors in the vicinity of the corridor door set by the entrance to the 100 Hall by Room 111. Findings include: Based on review of "Fire Door Inspection" documentation dated 03/26/24 with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m.		follow-up. 5. 5/19/2024	

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	on 04/18/24, fire door inspection documentation for "100 Hall East" stated "door sticks when closing". Based on interview at the time of record review, the Administrator stated she did not know if repairs to the door had been completed on or after the 03/26/24 fire door inspection as the new Maintenance Director just started working for the facility within the last two weeks. The fire door inspections were conducted by Majestic Care. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, each door in the corridor door set in the 100 Hall (east) by Room 111 was equipped with a 90-minute fire resistance rating label on the hinge side of the door. Each door was equipped with a self-closing device and latching hardware to latch each door latched into the door frame but the south door in the door set failed to fully self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the south door in the aforementioned corridor door set failed to fully self-close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to			

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 46 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section	K 0918	1. Weekly generator inspection was completed and will be done weekly and Monthly load check completed and will be done monthly. An automatic generator shut-off switch was installed outside of generator room. 2. No other findings. 3. The Maintenance Director will be educated by the Executive Director about the need for an	05/19/2024

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	6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Exercise generator (with no load)" with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, weekly emergency generator inspection documentation from 05/30/23 through 02/13/24 and from 02/27/24 through 04/16/24 was not available for review. Based on interview during the exit conference from 3:05 p.m. to 4:10 p.m. on 04/18/24, the Administrator agreed weekly emergency generator inspection documentation for the aforementioned weekly periods was not available for review. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to exercise the generator for 11 months of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust		automatic generator shut-off button outside of the generator room and that weekly generator inspections/monthly load testing must be completed on a weekly basis. 4. The Executive Director/designee upon completion will ensure done and documented with monthly fire drills. This information will be sent to QAPI for trending and completion follow-up. The Executive Director will confirm placement of automatic generator shut-off switch outside of generator room. 5. 5/19/2024	

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator Under Load" with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:55 p.m. on 04/18/24, load testing documentation for the eleven month period of May 2023 through March 2024 was not available for review. Based on interview during the exit conference from 3:05 p.m. to 4:10 p.m. on 04/18/24, the Administrator agreed load testing documentation for the eleven month period of May 2023 through March 2024 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, manufacturer's documentation affixed to the diesel fired generator located outside the facility on the south side of the property indicated it was manufactured in April 2012 and was rated at 60 kW.			

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	These findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1 requires the remote manual stop station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:55 p.m. to 3:05 p.m. on 04/18/24, the emergency generator was not equipped with a remote emergency stop button. The emergency generator for the facility is located outside the building in a weatherproof shell on the south side of the property. An emergency stop button was			

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	155376	A. BUILDING 01 B. WING	04/18/2024

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	located on the generator inside the weatherproof shell, but a remote emergency stop could not be located on the exterior of the weatherproof shell or at any other interior or exterior location on the premises. Manufacturer's documentation affixed to the diesel fired generator indicated it was manufactured in April 2012 and was rated at 60 kW. Based on interview at the time of observation, the Maintenance Director agreed a remote emergency stop for the emergency generator could not be located. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)			