| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155618 | A. BUILDING -- B. WING | 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MAJESTIC CARE OF CARMEL | 12999 N PENNSYLVANIA ST CARMEL, IN 46032 |

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| E 0000<br><br>Bldg. -- | A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/23/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 08/19/22<br><br>Facility Number: 001149<br>Provider Number: 155618<br>AIM Number: 200145500<br><br>At this PSR Emergency Preparedness survey, Majestic Care of Carmel was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 104 certified beds. At the time of the PSR survey, the census was 61.<br><br>Quality Review completed on 08/23/22 | E 0000 | | |
| K 0000<br><br>Bldg. 01 | A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/23/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 08/19/22<br><br>Facility Number: 001149<br>Provider Number: 155618<br>AIM Number: 200145500 | K 0000 | Facility requests paper compliance in lieu of on site revist on or before 8/30/22<br>="" b="">="" bthis="">="" bthe="">="" b="">="" b="">="" bthe="">="" b="">="" b="" | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | At this PSR Life Safety Code survey, Majestic Care of Carmel 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.<br><br>This two-story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident rooms. The healthcare portion of the facility has a capacity of 104 and had a census of 61 at the time of this PSR visit.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review completed on 08/23/22 | | | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>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 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not | | | |

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| | 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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |
| | Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 3 staff.<br><br>Findings include:<br><br>Based on a facility tour and interview with the Executive Director on 08/19/22 between 9:45 a.m. and 11:45 a.m., the Elevator Room corridor door, equipped with a self-closing device failed to latch positively into its door frame. The Executive | K 0363 | **K 363 CORRIDOR - DOORS**<br>Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 3 staff.<br><br>**Findings include:**<br><br>Based on a facility tour and | 08/30/2022 |

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| | Director stated he thought this repair had been completed, but acknowledged the condition was still present.<br>This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference with the Executive Director present.<br><br>This deficiency was originally cited on 06/23/22. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | | interview with the Executive Director on 08/19/22 between 9:45 a.m. and 11:45 a.m., the Elevator Room corridor door, equipped with a self-closing device failed to latch positively into its door frame. The Executive Director stated he thought this repair had been completed, but acknowledged the condition was still present.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by this practice?**<br><br>**The Executive Director oversaw the installation of a new door closer on the Elevator Room corridor room by CIH contractors on 8/23/2022. Installation included, but was not limited to installation of a new Closer, hooked up the foot and adjusted the speeds, removed the top 2 hinges and removed the wire behind the hinges to get a better gap on the strike side. Reinstalled the hinges.**<br><br>The installation of the new closer on the Door to the Elevator Room and adjustments was completed on 8/23/2022 and the door now closes and latches securely on its own. REPORT FROM CIH ATTACHED. | |

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| | | | **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>**· All residents, visitors, and staff have the potential to be affected by the alleged deficient practice.**<br><br>**The Executive Director and Maintenance staff reviewed all doors in the facility to ensure that they latch effectively to the door frames and all doors with self closers do so automatically.**<br><br>**What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?**<br><br>**The installation of the new closer on the Door to the Elevator Room and adjustments was completed on 8/23/2022 and the door now closes and latches securely on its own. REPORT FROM CIH ATTACHED.**<br><br>**All Maintenance staff were provided in-service training on the standard in NFPA 101** | |

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| | | | **Corridor – Doors specifically focusing on the requirement that corridor doors must latch, have door knobs, and close automatically if there is a closer.**<br><br>**· The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above.**<br><br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br><br>· The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved | |

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| | | | an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above.<br><br>The Elevator Room Door has been added as a weekly task to the TELS system to ensure that the door is given additional oversight weekly moving forward.<br><br>· **The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings.**<br><br>· **The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections.**<br><br>· **The Maintenance Director and Administrator are responsible for these results.** | |

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| K 0927<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 25 residents in 3 smoke compartments.<br><br>Findings include:<br><br>Based on a facility tour and interview with the Executive Director on 08/19/22 between 9:45 a.m. and 11:45 a.m., the corridor door to the Oxygen Transfilling room, equipped with self-closing hinges, failed to close, and latch positively into the door frame. The Executive Director stated that the door was scheduled to be replaced a few days ago, and he wasn't sure why it hadn't been done.<br><br>This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference with the Executive Director present. | K 0927 | **K 927 GAS EQUIPMENT – TRANSFILLING CYLINDERS**<br>**Based on observation and interview, the facility failed to ensure that 1 of 1 oxygen transfilling rooms was separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction.**<br><br>**Findings include:**<br><br>Based on a facility tour and interview with the Executive Director on 08/19/22 between 9:45 a.m. and 11:45 a.m., the corridor door to the Oxygen Transfilling room, equipped with self-closing hinges, failed to close, and latch positively into the door frame. The Executive Director stated that the door was scheduled to be replaced a few days ago, and he | 08/30/2022 |

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| | This deficiency was originally cited on 06/23/22. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | | wasn't sure why it hadn't been done.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by this practice?**<br><br>**· The Executive Director oversaw the installation of a new door to the Oxygen Transfilling Room by CIH contractors on 8/23/2022. Installation included, but was not limited to a new door, closer, lockset, hinges, swung the new door, hooked up the door closer foot and adjusted the speeds.**<br><br>**The door installation to the Oxygen Transfilling Room was completed on 8/23/2022 and the door closes automatically and latches positively to the door frame ensuring that the oxygen transfilling room is separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction.**<br><br>**How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>**· All residents, visitors, and staff have the potential to** | |

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| | | | **be affected by the alleged deficient practice.**<br><br>**The Executive Director oversaw the installation of a new door to the Oxygen Transfilling Room by CIH contractors on 8/23/2022. Installation included, but was not limited to a new door, closer, lockset, hinges, swung the new door, hooked up the door closer foot and adjusted the speeds.**<br><br>**The door installation to the Oxygen Transfilling Room was completed on 8/23/2022 and the door closes automatically and latches positively to the door frame ensuring that the oxygen transfilling room is separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction. REPORT FROM CIH ATTACHED**<br><br>**What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?**<br><br>**· The Oxygen Transfilling Room door installation was completed on 8/23/2022. Installation included, but was not limited to a new door, closer, lockset, hinges, swung** | |

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| | | | **the new door, hooked up the door closer foot and adjusted the speeds. REPORT FROM CIH ATTACHED.**<br><br>**· The Executive Director/designee will complete Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above.**<br><br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br><br>**· The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be** | |

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| | | | **completed at the conclusion of construction in addition to the CQI schedule set forth above.**<br><br>**- The Oxygen Transfilling Room has been added as a weekly task to the TELS system to ensure that the door is given additional oversight weekly moving forward.**<br><br>**· The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings.**<br><br>**· The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections.**<br><br>**· The Maintenance Director and Administrator are responsible for these results.** | |