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	07/01/2024

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: 07/01/24 Facility Number: 000040 Provider Number: 155100 AIM Number: 100274460 At this Emergency Preparedness survey, Majestic Care of Bedford was found in substantial 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 94. Quality Review completed on 07/03/24	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 prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during an Annual Survey. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Cox		07/19/2024

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.

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	07/01/2024

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
	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0004	1. The facility IDT team met to	07/26/2024

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	07/01/2024

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
	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 07/01/24 at 12:30 p.m. with the Maintenance Director present, documentation for an updated emergency preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented update being listed as 01/16/2023. Based on interview at the time of record review, the Maintenance Director said a new Administrator had recently started and he had not had an opportunity to review the emergency preparedness plan as of time and date of this survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		review the Emergency Preparedness Plan and update as necessary. 2. The facility IDT team met to review the Emergency Preparedness Plan and update as necessary. 3. The ED/Designee in serviced the Maintenance Director on the facilities Emergency Preparedness Policy and Procedure. 4. The ED/Designee will review the Emergency Preparedness plan monthly x 12 months to ensure that the plan has been reviewed and updated as necessary. Results of the audits will be reviewed during monthly QAPI meeting to ensure continued compliance. Audits will be reviewed by the QAPI Committee until such time consistent with substantial compliance has been achieved as determined by the committee. Audited records will be reviewed by the Risk Management/Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b),			

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	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(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
	491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	155100	A. BUILDING -- B. WING	07/01/2024

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan on 07/01/24 at 12:30 p.m. with	E 0013	1. The facility IDT team met to review the Emergency Preparedness Plan and update as necessary. 2. The facility IDT team met to review the Emergency Preparedness Plan and update as necessary. 3. The ED/Designee in serviced the Maintenance Director on the	07/26/2024

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	the Maintenance Director, documentation for updated policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 01/16/24. Based on interview at the time of record review, the Maintenance Director agreed the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		facilities Emergency Preparedness Policy and Procedure. 4. The ED/Designee will review the Emergency Preparedness plan monthly x 12 months to ensure that the plan has been reviewed and updated as necessary. Results of the audits will be reviewed during monthly QAPI meeting to ensure continued compliance. Audits will be reviewed by the QAPI Committee until such time consistent with substantial compliance has been achieved as determined by the committee. Audited records will be reviewed by the Risk Management/Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication			

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	155100	A. BUILDING -- B. WING	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 07/01/24 at 12:30 p.m. with the Maintenance Director, documentation for an updated communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 01/16/23. Based on interview at the time of record review, the Maintenance Director confirmed the entire emergency preparedness program had not been reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0029	1. The facility IDT team met to review the Emergency Preparedness Plan and update as necessary. 2. The facility IDT team met to review the Emergency Preparedness Plan and update as necessary. 3. The ED/Designee in serviced the Maintenance Director on the facilities Emergency Preparedness Policy and Procedure Communication Plan. 4. The ED/Designee will review the Emergency Preparedness Communication plan monthly x 12 months to ensure that the plan has been reviewed and updated as necessary. Results of the audits will be reviewed during monthly QAPI meeting to ensure continued compliance. Audits will be reviewed by the QAPI Committee until such time consistent with substantial compliance has been achieved as determined by the committee. Audited records will be reviewed by the Risk Management/Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.	07/26/2024

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	155100	A. BUILDING -- B. WING	07/01/2024

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

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E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness testing and training program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	1. The facility IDT team met to review the Emergency Preparedness Plan and update as necessary. 2. The facility IDT team met to review the Emergency	07/26/2024

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	Findings include: Based on review of the facility's Emergency Preparedness Plan on 07/01/24 at 12:30 p.m.. with the Maintenance Director, documentation for an updated testing and training program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 01/16/23. Based on interview at the time of record review, the Maintenance Director agreed the facility has not had its entire emergency preparedness program reviewed within the most recent twelve-month period. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		Preparedness Plan and update as necessary. 3. The ED/Designee in serviced the Maintenance Director on the facilities Emergency Preparedness Policy and Procedure on testing/training. 4. The ED/Designee will review the Emergency Preparedness plan testing and training monthly x 12 months to ensure that the plan has been reviewed and updated as necessary. Results of the audits will be reviewed during monthly QAPI meeting to ensure continued compliance. Audits will be reviewed by the QAPI Committee until such time consistent with substantial compliance has been achieved as determined by the committee. Audited records will be reviewed by the Risk Management/Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.	
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: 07/01/24	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	

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	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 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 94 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 07/03/24		correctly. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during an Annual Survey. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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. Records of system design, maintenance,			

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	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 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, 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 review of " Dry Pipe Fire Sprinkler System" inspection documentation dated 05/07/24 during record review with the Maintenance Director from 10:10 a.m. to 12:30 p.m. on 07/01/24,	K 0353	1. No residents were harmed due to the alleged deficiency. The sprinkler system was check and if fully operational. The sprinkler head identified during the survey has been replaced. The accelerator identified is functional and a new one has been ordered to replace the current one The accelerator had to be ordered and is scheduled to be installed by 8.9.24 (see attached vendor letter). 2. No residents were harmed due to the alleged deficiency. All residents have the potential to be affected by the alleged deficient practice. The sprinkler system was check and if fully operational. The sprinkler head identified during the survey has been replaced. The accelerator identified is functional and a new one has been ordered to replace the current one. 3. ED/designee in serviced Maintenance Director on the	08/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. BUILDING 01 B. WING	07/01/2024

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

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	the 'accelerator shut off' was noted in the comments section. Based on interview at the time of record review, the Maintenance Director stated he contacted the vendor who stated the accelerator needed to be rebuilt and would send a quote for repair. The Maintenance Director stated the repair has not been completed and confirmed documentation of the repair or replacement of the aforementioned sprinkler system accelerator on or after 05/07/24 was not available for review. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 2. Based on observation, and interview; the facility failed to ensure 1 of 2 sprinkler heads in the Dietary Office with a bent deflector was replaced 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.		facilities Fire System Policy and procedure. 4. ED/designee will conduct audits to ensure that the accelerator is functioning and that there are no sprinkler heads that are bent Monthly x 12 months. Results of the audits will be reviewed during monthly QAPI meeting to ensure continued compliance. Audits will be reviewed by the QAPI Committee until such time consistent with substantial compliance has been achieved as determined by the committee. Audited records will be reviewed by the Risk Management/Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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	This deficient practice could affect staff in the Dietary Office. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 1:25 p.m. on 07/01/24, the sprinkler located closest to the closets in the Dietary office had a bent and damaged deflector. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler had a bent deflector. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0712 SS=F 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 fire drills on each shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under	K 0712	1. No residents were harmed by the alleged deficient practice. The facilities fire drills were conducted on both 12 hour shifts that is in place.	07/26/2024

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	varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 07/01/24 at 10:45 a.m., the following was noted: a) no documentation was available to show a second shift fire drill for the second quarter of 2024 b) no documentation was available to show a third shift fire drill for the third quarter of 2023 c) no documentation was available to show a first shift fire drill for the fourth quarter of 2023 Based on an interview at the time of record review, the Maintenance Director stated fire drills were conducted a second time on other shifts, such as two third shift drills in the second quarter, and the aforementioned shift drills were not conducted. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		2. No residents were harmed by the alleged deficient practice. All residents have the potential of being affected by the alleged deficient practice. The facilities fire drills were conducted on both 12 hour shifts that is in place. 3. ED/designee in serviced the Maintenance Director on the facilities Fire Drill Policy and Procedure. 4. ED/Designee will audit fire drills monthly x 12 months to ensure the required time gap between drills is in compliance. Results of the audits will be reviewed during monthly QAPI meeting to ensure continued compliance. Audits will be reviewed by the QAPI Committee until such time consistent with substantial compliance has been achieved as determined by the committee. Audited records will be reviewed by the Risk Management/Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee.	