PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155100		A. BUILDING B. WING			
	PROVIDER OR SUPPLIE		2111 N	ADDRESS, CITY, STATE, ZIP COD NORTON LN DRD, IN 47421	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 07/0 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provider Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Provides Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Number: 100 At this Emergency Care of Bedford w compliance with E Requirements for N Participating Number: 100 At this Emergency Care of Bed	1/24  000040 155100 0274460  Preparedness survey, Majestic as found in substantial mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR  0 certified beds. At the time of	E 0000	This Plan of Correction constitution that facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exists, or that one was cited correctly. The Plan of Correct prepared and executed solely because it is required by the position of Federal and State. The Plan of Correction is submitted to respond to the allegation of noncompliance of during an Annual Survey. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance.	of of es of this cion is of law.
E 0004 SS=C Bldg	441.184(a), 482.2 484.102(a), 485.6 485.727(a), 485.6 491.12(a), 494.62 Develop EP Plan Annually §403.748(a), §41 §441.184(a), §46 §483.73(a), §483 §485.68(a), §485 §485.920(a), §48 §494.62(a).	920(a), 486.360(a),			
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE	(X6) DATE

Joe Cox 07/19/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays 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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	OF CORRECTION	IDENTIFICATION NUMBER  155100	A. BUILDING B. WING	onstruction 	COMPLETED 07/01/2024
	ROVIDER OR SUPPLIER		2111 N	ADDRESS, CITY, STATE, ZIP COD ORTON LN ORD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	Federal, State and preparedness required must develop estate comprehensive emprogram that meet section. The emer program must include the following elem  (a) Emergency Pladevelop and maintiperparedness plar and updated at least must do all of the section. The emergency Plane or CAH] must comprehensive emprogram that meet section, utilizing at the section, utilizing at the section of the sectio	d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this gency preparedness ude, but not be limited to, ents:  an. The [facility] must tain an emergency that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital hely with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this in all-hazards approach.  es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed,	TAG	DEFICIENCY	
	and updated at lea	view and interview, the facility	E 0004		07/26/2024
	failed to develop an	d maintain an emergency		The facility IDT team met to	

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING  155100 B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/01/2024		
	PROVIDER OR SUPPLIER		2111 N	ADDRESS, CITY, STATE, ZIP COD ORTON LN ORD, IN 47421		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	preparedness plan t at least annually in 483.73(a). This def occupants.  Findings include:  Based on record reversed preparedness Plan of the Maintenance Defor an updated emereviewed by the fact twelve-month period The emergency plareviewed within the documented update Based on interviewenthe Maintenance Deformation Administrator had a had an opportunity preparedness plan a survey.  This finding was reserved.	hat was reviewed and updated accordance with 42 CFR icient practice could affect all view of the facility's Emergency on 07/01/24 at 12:30 p.m. with irector present, documentation regency preparedness program willity within the most recent id was not available for review. In available had not been to past 12 months with the last ibeing listed as 01/16/2023. The time of record review, irector said a new recently started and he had not to review the emergency as of time and date of this viewed with the Administrator irector at the exit conference.	TAG	review the Emergency Preparedness Plan and update necessary.  2. The facility IDT team met to review the Emergency Preparedness Plan and update necessary.  3. The ED/Designee in service the Maintenance Director on the facilities Emergency Preparedness Policy and Procedure.  4. The ED/Designee will reviee Emergency Preparedness plate 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 QAP meeting to ensure continued compliance. Audits will be reviewed by the QAPI Commit until such time consistent with substantial compliance has be achieved as determined by the committee. Audited records we reviewed by the Risk Management/Quality Assurant committee until such time consistent substantial compliants been achieved as determined by the committee.	e as e as e as ed he withe need I ttee een e iill be ce nce	DATE
E 0013 SS=C Bldg	484.102(b), 485.6	5(b), 483.475(b), 483.73(b),				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155100	i '	UILDING	NSTRUCTION	COMP	E SURVEY PLETED 1/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2111 NORTON LN BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
TAG	491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b).  (b) Policies and p develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The policities and procedures. The policities and procedures pol on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The policities and procedures. The policities and procedures pol on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The policities be reviewed and of *Additional Require ESRD Facilities:  *[For PACE at §46]	(b) (P Policies and Procedures 6.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b),  rocedures. [Facilities] must ement emergency icies and procedures, based y plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2  s at §483.73(b):] Policies (The LTC facility must ement emergency icies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.  The ements for PACE and (60.84(b):] Policies and		TAG		PINALE	DATE
	develop and imple preparedness pol on the emergency	PACE organization must ement emergency icies and procedures, based or plan set forth in paragraph risk assessment at					

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	COMPLETED	
155100 B. WING 07/01/2024		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF BEDFORD  STREET ADDRESS, CITY, STATE, ZIP COD 2111 NORTON LN BEDFORD, IN 47421		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDEDS BLANGE CORRECTION (X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED	ION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE		
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 $E 0013$ 1. The facility IDT team met to $07/26/2$	024	
failed to develop and implement emergency review the Emergency		
preparedness policies and procedures. The Preparedness Plan and update as		
policies and procedures must be reviewed and necessary.		
updated at least annually in accordance with 42		
CFR 483.73(b). This deficient practice could affect  2. The facility IDT team met to		
all residents in the facility.		
Preparedness Plan and update as		
Findings include: necessary.		
Based on review of the facility's Emergency  3. The ED/Designee in serviced		
Preparedness Plan on 07/01/24 at 12:30 p.m. with  the Maintenance Director on the		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155100	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE S COMPLE 07/01/2	TED
	PROVIDER OR SUPPLIER		2111 N	ADDRESS, CITY, STATE, ZIP COI NORTON LN ORD, IN 47421	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	updated policies and facility within the nuperiod was not avail	rector, documentation for d procedures reviewed by the most recent twelve-month lable for review. The vided had not been reviewed		facilities Emergency Preparedness Policy and Procedure.  4. The ED/Designee will		
	documented review on interview at the Maintenance Direct had its entire emerg reviewed by the fac	ve months with a last date listed as 01/16/24. Based time of record review, the or agreed the facility has not ency preparedness program ility within the most recent		Emergency Preparedness monthly x 12 months to a that the plan has been reand updated as necessar Results of the audits will reviewed during monthly	ensure eviewed ary. be r QAPI	
		d. viewed with the Administrator irector at the exit conference.		meeting to ensure conting compliance. Audits will be reviewed by the QAPI Countil such time consistent substantial compliance hachieved as determined committee. Audited recorreviewed by the Risk Management/Quality Associated to the consistent substantial counties been achieved as despite the committee.	oe ommittee at with nas been by the ards will be surance e ompliance	
E 0029 SS=C Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),				
	1 ' '	ust develop and maintain paredness communication				

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	NT OF DEFICIENCIES OF CORRECTION			ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/01/2024		
	PROVIDER OR SUPPLIER			2111 N	ADDRESS, CITY, STATE, ZIP COD ORTON LN ORD, IN 47421		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	DDEELY (EAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
	plan that complies local laws and must least every 2 ye facilities]. Based on record rerestailed to develop ar preparedness community Federal, State, with 42 CFR 483.7 could affect all occurs of Findings include:  Based on review of Preparedness Plan of the Maintenance Diupdated communication facility within the reperiod was not avaited emergency plan prowithin the past tweld documented review on interview at the Maintenance Direct emergency prepared reviewed by the fact twelve-month period.	is with Federal, State and ust be reviewed and updated ears [annually for LTC] wiew and interview, the facility and maintain an emergency nunication plan that complies and local laws in accordance 3(c). This deficient practice upants.  The facility's Emergency on 07/01/24 at 12:30 p.m. with irrector, documentation for an action plan reviewed by the most recent twelve-month lable for review. The ovided had not been reviewed live months with a last of date listed as 01/16/23. Based time of record review, the tor confirmed the entire dness program had not been cility within the most recent	EO		(EACH CORRECTIVE ACTION SHOULD BE	e as e as e as ed he an. w the x 12 n ed as its ly nued ttee een e eill be	
					has been achieved as determined by the committee.		

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Event ID:

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PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155100	A. BUILDING  B. WING		CON	TE SURVEY MPLETED 01/2024
	PROVIDER OR SUPPLIER		2111 N	ADDRESS, CITY, STATE, ZI ORTON LN PRD, IN 47421	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 0036 SS=C Bldg	484.102(d), 485.62 485.727(d), 485.92 491.12(d), 494.62(EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §485.6 §485.920(d), §486 §494.62(d).  *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs at §486.360, and RH Training and testing develop and maint preparedness trair that is based on the in paragraph (a) of assessment at parasection, policies are (b) of this section, plan at paragraph training and testing reviewed and update in the emergency plan of this section, risk (a)(1) of this section, risk (a)(1) of this section.	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) esting 5.54(d), §418.113(d), 1.84(d), §482.15(d), 475(d), §484.102(d), 525(d), §485.727(d), 1.360(d), §491.12(d), 1.3 PRTFs at §441.184, 1.3 PRTFs at §442.15, 1.4 CORFs at §485.68, 1.5 CORFs at §485.68, 1.7 Crganizations" under at §485.920, OPOs at C/FHQs at §491.12:] (d) 19. The [facility] must 19. The [facility] must 19. The program 19. The emergency 19. The program 19. The emergency 19. The emergency 19. The forth				

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	OF CORRECTION	IDENTIFICATION NUMBER  155100	A. BUII B. WIN	DING		COMPL 07/01/	ETED
	PROVIDER OR SUPPLIER			2111 NC	DDRESS, CITY, STATE, ZIP COD DRTON LN RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	communication plasection. The train must be reviewed annually.  *[For ICF/IIDs at §	an at paragraph (c) of this ing and testing program and updated at least 483.475(d):] Training and D must develop and					
	maintain an emergand testing progratemergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication playsection. The train must be reviewed 2 years. The ICF/II	gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every					
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section. The orientation prograupdated at every 2						
	failed to develop an preparedness testing was reviewed and u	riew and interview, the facility d maintain an emergency g and training program that pdated at least annually in CFR 483.73(d). This deficient t all occupants.	E 003	86	<ol> <li>The facility IDT team met to review the Emergency Preparedness Plan and update necessary.</li> <li>The facility IDT team met to review the Emergency</li> </ol>	e as	07/26/2024

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	T OF DEFICIENCIES OF CORRECTION	i i i i i i i i i i i i i i i i i i i		(X3) DATE SURVEY COMPLETED 07/01/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2111 NORTON LN BEDFORD, IN 47421				
(X4) ID PREFIX TAG	REGULATORY OF Findings include:  Based on review of Preparedness Plan of the Maintenance Diupdated testing and the facility within the period was not availemergency plan prowithin the past twel documented review on interview at the Maintenance Direct had its entire emergereviewed within the period.  This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  The facility's Emergency on 07/01/24 at 12:30 p.m with rector, documentation for an training program reviewed by the most recent twelve-month lable for review. The twided had not been reviewed twe months with a last the date listed as 01/16/23. Based time of record review, the tor agreed the facility has not trency preparedness program the most recent twelve-month  wiewed with the Administrator irector at the exit conference.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION TO THE	e as e as ed as to the an	(X5) COMPLETION DATE
K 0000 Bldg. 01					consistent substantial complia has been achieved as determi by the committee.		
Diag. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR	K 0	000	This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exists, or that one was cited	of S	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>		COMPLETED	
		155100	B. W	ING		07/01/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				ORTON LN		
MAJESTI	IC CARE OF BEDF	ORD			RD, IN 47421		
	T				, ··· · <del>-</del> ·		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	Facility Number: 0 Provider Number:				correctly. The Plan of Correcti	on is	
					prepared and executed solely		
	AIM Number: 100274460				because it is required by the		
	At this I if Safet (	Code survey Majestic Core of			position of Federal and State I	aw.	
		Code survey, Majestic Care of not in compliance with			The Plan of Correction is		
	Requirements for Pa	-			submitted to respond to the allegation of noncompliance of	itad	
	_	articipation in , 42 CFR Subpart 483.90(a),			during an Annual Survey. The		
		re and the 2012 edition of the			provider respectfully requests		
	I -	etion Association (NFPA) 101,			review with paper compliance		
		SC), Chapter 19, Existing			be considered in establishing		
		ancies and 410 IAC 16.2.			the provider is in substantial		
	l are soupe				compliance.		
	This two story split	level facility with each of the			·I- · · - · · · - ·		
		t ground level was determined					
	_	0) construction and was fully					
		ility has a fire alarm system					
	with smoke detection	on on both levels in the					
	corridors and in all	areas open to the corridor. The					
	facility has battery of	operated smoke alarms					
		ent sleeping rooms. The					
		ty of 190 and had a census of					
	94 at the time of this	s survey.					
		residents have customary					
		ered. All areas providing					
		re sprinklered except for one					
	detached storage bu	ilding.					
	O114 P	1.4.1 07/02/24					
	Quality Review con	ipieted on 07/03/24					
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
g. 0 1		er and standpipe systems					
		ted, and maintained in					
	1	IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					

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	R MEDICARE & MEDIC						B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED 07/01/2024			
	PROVIDER OR SUPPLIER		2	2111 NO	DRTON LN RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	b) Who provided c) Water system Provide in REMAI coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record facility failed to ma systems in accordar requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Wa Systems. NFPA 25 states the property representative shall or impairments that inspection, test and standard. Correction performed by qualified contract records shall be made and maintenance of shall be made avail jurisdiction upon recould affect all resifacility. Findings include:  Based on review of	supply source  RKS information on non-required or partial er system.	K 035	3	1. No residents were harmed to the alleged deficiency. The sprinkler system was check ar fully operational. The sprinkler head identified during the survhas been replaced. The accelerator identified is functionand a new one has been ordered to replace the current one The accelerator had to be ordered is scheduled to be installed by 8.9.24 (see attached vendor letter).  2. No residents were harmed to the alleged deficiency. All residents have the potential to affected by the alleged deficie practice. The sprinkler system was check and if fully operation The sprinkler head identified of the survey has been replaced accelerator identified is functionand a new one has been order to replace the current one.	nd if rey onal red and due be nt nal. luring The	08/09/2024

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during record review with the Maintenance

Director from 10:10 a.m. to 12:30 p.m. on 07/01/24,

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3. ED/designee in serviced

Maintenance Director on the

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		COMPLETED		
		155100	B. WING			07/01/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ORTON LN		
MAJESTIC CARE OF BEDFORD				BEDFORD, IN 47421			
					, 		OV.E.
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD I  CROSS-REFERENCED TO THE APPROP			(X5)
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	COMPLETION DATE	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION the 'accelerator shut off' was noted in the			TAG		DATE	
		Based on interview at the time			facilities Fire System Policy and procedure.		
		e Maintenance Director stated			procedure.		
	he contacted the ver			4. ED/designee will conduct audits			
	accelerator needed to be rebuilt and would send a			to ensure that the accelerator is			
		e Maintenance Director stated		functioning and that there are no			
		een completed and confirmed		sprinkler heads that are bent			
		ne repair or replacement of the		Monthly x 12 months. Results of		of	
	aforementioned sprinkler system accelerator on or			the audits will be reviewed durir			
	after 05/07/24 was not available for review.				monthly QAPI meeting to ensu	•	
					continued compliance. Audits		
	This finding was reviewed with the Administrator				be reviewed by the QAPI		
	and Maintenance D	irector at the exit conference.			Committee until such time		
					consistent with substantial		
	2. Based on observation, and interview; the				compliance has been achieved as		
	facility failed to ensure 1 of 2 sprinkler heads in				determined by the committee.		
	the Dietary Office with a bent deflector was				Audited records will be reviewed		
	replaced in accordance with NFPA 25. NFPA 25,				by the Risk Management/Quality		
	Standard for the Inspection, Testing, and				Assurance committee until such		
	Maintenance of Water-Based Fire Protection			time consistent substantial			
	Systems, 2011 Edition, Section 5.2.1.1.1 states			compliance has been achieved as			
	sprinklers shall not show signs of leakage; shall				determined by the committee.		
		, foreign materials, paint, and					
		nd shall be installed in the					
		(e.g., up-right, pendent, or					
		nore, at 5.2.1.1.2 any sprinkler					
		any of the following shall be					
	replaced:						
	(1) Leakage						
	(2) Corrosion						
	(3) Physical Damag						
		the glass bulb heat responsive					
	element						
	(5) Loading	painted by the sprinkler					
	(6) Painting unless j	painted by the sprinkler					
		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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155100		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/01/2024			
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF BEDFORD			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Dietary Office.	ice could affect staff in the					
	Director during a to 07/01/24, the sprink closets in the Dietar damaged deflector. of observation, the I the sprinkler had a but This finding was rev	on with the Maintenance ur of the facility at 1:25 p.m. on eller located closest to the y office had a bent and Based on interview at the time Maintenance Director agreed bent deflector.  Viewed with the Administrator irector at the exit conference.					
K 0712 SS=F Bldg. 01	alarm signal and signal and signal and unexpected time conditions, at least The staff is familia aware that drills are routine. Where dried 9:00 PM and 6:00 announcement manualible alarms.  19.7.1.4 through 1 Based on record revisions.	t quarterly on each shift. r with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of  9.7.1.7 riew and interview, the facility	K 0712		07/26/2024		
	quarters. LSC 19.7. conducted quarterly facility personnel (n engineers, and admi	e drills on each shift for 3 of 4 1.6 states drills shall be on each shift to familiarize surses, interns, maintenance inistrative staff) with the ney action required under		1. No residents were harmed the alleged deficient practice. facilities fire drills were conduon both 12 hour shifts that is i place.	The cted		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155100	B. WING		07/01/2024		
			CTDEE	TADDRESS CITY STATE 7ID COD			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2111 NORTON LN				
MAJESTIC CARE OF BEDFORD			BEDFORD, IN 47421				
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X	5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLI	ETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Έ		
	varied conditions. This deficient practice affects			2. No residents were harmed			
	all staff and residents.  Findings include:  Based on records review with the Maintenance			the alleged deficient practice.	All		
				residents have the potential of	f		
				being affected by the alleged			
				deficient practice. The facilities			
				drills were conducted on both	12		
	Director on 07/01/24 at 10:45 a.m., the following was noted:			hour shifts that is in place.			
	a) no documentation was available to show a			3. ED/designee in serviced the			
	second shift fire drill for the second quarter of			Maintenance Director on the			
	2024			facilities Fire Drill Policy and			
	b) no documentation was available to show a third shift fire drill for the third quarter of 2023			Procedure.			
	c) no documentation was available to show a first			4. ED/Designee will audit fire	drills		
	shift fire drill for the fourth quarter of 2023			monthly x 12 months to ensure			
	Based on an interview at the time of record review,			the required time gap between			
	the Maintenance Director stated fire drills were			drills is in compliance. Results of			
	conducted a second time on other shifts, such as			the audits will be reviewed during			
	two third shift drills in the second quarter, and the			monthly QAPI meeting to ensure			
	aforementioned shift drills were not conducted.  This finding was reviewed with the Administrator and the Maintenance Director during the exit			continued compliance. Audits			
				be reviewed by the QAPI			
				Committee until such time			
				consistent with substantial			
	conference.			compliance has been achieved as			
				determined by the committee			
	3.1-19(b)			Audited records will be review			
	3.1-51(c)			by the Risk Management/Qua			
				Assurance committee until su	ch		
				time consistent substantial			
			compliance has been achieve				
				determined by the committee			

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