STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155689	A. BUILDING -- B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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: 02/25/25 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this Emergency Preparedness survey, Majestic Care of Goshen was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 186 certified beds. At the time of the survey, the census was 110. Quality Review completed on 02/28/25	E 0000	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** ***Majestic Care of Goshen respectfully asks for consideration of a desk review***	
E 0007 SS=F Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(EP Program Patient Population Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all residents. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no documentation was provided ensuring the emergency preparedness plan	E 0007	**E007 EP Program Patient Population** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident population added to the EP binder. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same**	03/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Shepperd	Executive Director	03/18/2025

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	addressed resident population, including, but not limited to, persons at-risk. Based on interview at the time of record review, the Maintenance Director stated a new updated emergency preparedness plan is currently being worked on, he also stated that he has not been in his position very long and has not reviewed the current plan. This finding was reviewed with the Maintenance Director at the exit conference.		**deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all EP binders include resident population. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that EP binders include resident population. Maintenance/designee will audit all EP binders 1x weekly x6 months to ensure EP binders include resident population. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect resident population included in the EP binder. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.1 Subsistence Needs for Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all residents and staff. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no policy, plan or procedure was provided regarding food, medical, and pharmaceutical supplies. Based on interview, the Maintenance Director stated a new updated emergency preparedness plan is currently being worked on, he also stated that he has not been in his position very long and has not reviewed the current plan. This finding was reviewed with the Maintenance Director at the exit conference.	E 0015	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **E015 Subsistence Needs for Staff and Patients** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Emergency evacuation policy added to the EP binder including pharmacy process and procedures, emergency food process, as well as emergency water. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all EP binders include the policies for emergency evacuation including emergency pharmacy, food, and water policies.	03/14/2025

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			What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? ·All staff educated on the need to ensure that EP binders include emergency evacuation policies encompassing emergent pharmacy, food, and water supplies. Maintenance/designee will audit all EP binders 1x weekly x6 months to ensure EP binders include updated emergency evacuation policies, including pharmacy, food, and water supplies. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect emergency evacuation policies are included in the EP binder that include emergent pharmacy, food, and water supplies. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(Procedures for Tracking of Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all residents and staff. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no policies or procedures that included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, the Maintenance Director referred to the facility's evacuation plan; however, the plan only discussed evacuation and relocation and did not refer to a tracking system in place. This finding was reviewed with the Maintenance Director at the exit conference.	E 0018	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **E018 Procedures for Tracking Staff and Patients** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Emergency evacuation policy added to the EP binder that included tools for tracking both staff and resident population. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all EP binders include the policies for emergency evacuation including resident and staff population and tracking tools. **What measures will be put into**	03/14/2025

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			place or what systematic changes will you make to ensure that the deficient practices do not recur? ·All staff educated on the need to ensure that EP binders include emergency evacuation policies encompassing staff and resident tracking. Maintenance/designee will audit all EP binders 1x weekly x6 months to ensure EP binders include updated emergency evacuation policies, including staff and resident tracking tools. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect emergency evacuation policies are included in the EP binder that include staff and resident population. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
E 0030 SS=F Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information Based on record review and interview, the facility	E 0030	***Majestic Care of Goshen please***	03/14/2025

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	failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no documentation was provided which ensured the communication plan included names and contact information for staff, residents' physicians, other LTC facilities or volunteers. The communication plan did include a list of vendors and other entities providing services. This deficient practice could affect all residents and staff. This finding was reviewed with the Maintenance Director at the exit conference.		***accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **E030 Names and Contact Information** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Names and contact information for staff, entities providing services, resident physicians, and LTC facilities added to the EP binder. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all EP binders include the contact information for staff, entities providing services, resident physicians, and LTC facilities in the county. **What measures will be put into place or what systematic changes will you make to ensure that the deficient**	

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			practices do not recur? ·All staff educated on the need to ensure that EP binders include names and contact information for staff, entities providing services, resident physicians and LTC facilities in the county. Maintenance/designee will audit all EP binders 1x weekly x6 months to ensure EP binders include updated contact information of above entities. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect all contact information is included in the EP binder that include contact information of all entities listed above. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State,	E 0031	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of***	03/14/2025

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	tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, the emergency preparedness communication plan included "911" as the contact phone number for local police, fire and emergency medical services, but failed to include contact information for Federal, State, tribal, or regional, the State Licensing and Certification Agency, the Office of the State Long-Term Care Ombudsman or other sources of assistance. This finding was reviewed with the Maintenance Director at the exit conference.		***correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **E031 Emergency Officials Contact Information** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Emergency officials' contact information for Federal, State, tribal, regional, ISDH, and the Ombudsman added to the EP binder. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all EP binders include the contact information for Emergency personnel. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that EP binders include and contact information for emergency personnel.	

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			Maintenance/designee will audit all EP binders 1x weekly x6 months to ensure EP binders include updated contact information of above entities. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect all contact information is included in the EP binder that include contact information of all entities listed above. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually;	E 0037	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **E037 EP Training Program** **What corrective action will be**	03/14/2025

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	(iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on record review and interview, a printed copy of training conducted using the computer based Relias system was provided; however, no emergency preparedness training was listed in the completed training. No additional documentation to show evidence of EPP training was provided to show initial or annual training or staff knowledge of emergency procedures. This finding was reviewed with the Maintenance Director at the exit conference.		**accomplished for those residents found to have been affected by the deficient practice?** ·Annual EPP training provided to all staff. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure EPP training took place for all staff. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on EPP. Staff further educated on the need to ensure that annual training takes place for EPP. Maintenance/designee will audit all EPP training 1x weekly x6 months to ensure EP training is taking place upon hire and annually. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect all	

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			EP training is completed upon hire and annually. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using	E 0039	**E039 EP Testing Requirements** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Emergency drill conducted for "Active Shooter" and a tornado drill for 2025. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all EP binders include emergency drills conducted within 12 months. **What measures will be put into place or what systematic changes will you make to ensure that the deficient**	03/14/2025

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	a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, the facility failed to provide documentation of any emergency exercises conducted in the last 12 months. Based on interview, the Maintenance Director stated an active shooter exercise was conducted but was not in the last 12 months. This finding was reviewed with the Maintenance Director at the exit conference.		**practices do not recur?** ·All staff educated on the need to ensure that EP binders include updated emergency drills. Maintenance/designee will audit all EP binders 1x monthly x6 months to ensure EP binders include updated emergency drills. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect all emergency drills are conducted at least annually. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
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: 02/25/25 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080	K 0000	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.***	

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	At this Life Safety Code survey, Majestic Care of Goshen 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The building is partially protected by two 200 kW natural gas-powered emergency generators. The facility has a capacity of 186 and had a census of 110 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was sprinklered, and two detached storage sheds that were not sprinklered. Quality Review completed on 02/28/25		***Majestic Care of Goshen respectfully asks for consideration of a desk review***	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on observation, record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3	K 0291	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.***	03/14/2025

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	weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (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 record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, documentation of testing of exit signs was provided; however, no documentation of testing for an emergency light was available for review. Based on observation with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, a battery powered emergency light was located in the mechanical room leading outside to the generator area. At the time of observation the Maintenance Director acknowledged the emergency light and stated he did not test it. 3.1-19(b)		**K 291 Emergency Lighting** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Battery powered emergency light that was located in the mechanical room leading outside to the generator area was tested annually for at least 90 minutes. Additionally, the battery backup light is tested monthly for at least 30 seconds. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all battery powered emergency lights were tested annually for at least 90 minutes. Additionally, the battery backup light was tested monthly for at least 30 seconds. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that all battery powered emergency lights were tested annually for at least 90 minutes. And backup light tested monthly	

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			for at least 30 seconds. Maintenance/designee will audit all documentation for battery powered emergency lights 1x monthly x6 months to ensure battery powered emergency lights were tested. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect ensure that all battery powered emergency lights were tested. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1.) Based on record review, observation and interview; the facility failed to provide documentation of 1 of 1 kitchen exhaust system annual or semiannually cleaning and inspection. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table	K 0324	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **K 324 Cooking Facilities** **What corrective action will be**	03/14/2025

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	11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no documentation was provided to show an inspection or cleaning of the kitchen hood exhaust system had been conducted. Based on interview, the Maintenance Director stated the kitchen hood exhaust cleaning had been completed; however, no documentation was provided at the time of survey. 2.) Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial		**accomplished for those residents found to have been affected by the deficient practice?** Documentation obtained to show that inspection/cleaning of the kitchen hood exhaust system completed. No ill effect due to alleged deficient practice. Kitchen staff needed trained on the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Facility marked designated areas for returning cooking appliances to where they were under the kitchen hood extinguishing equipment when the cooking appliances are moved for the purposes of maintenance and cleaning. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all inspections/cleanings is on file for the kitchen hood exhaust systems and that there was a clearly marked area to return cooking appliances to where they were under the kitchen hood extinguishing equipment when the cooking appliances are moved for	

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	Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, the kitchen was provided with a UL 300 hood fire suppression system. Based on interview during tour of the kitchen, Cook #1 was asked what she would do if there was a grease fire underneath the hood. She stated she would use a fire extinguisher. The surveyor asked Cook #1 what other steps she would take, and she stated she would pull the fire alarm. Cook #2 was asked the same question at the same time; however, she did not have a different answer. Based on interview with the Maintenance Director, he acknowledged that kitchen staff needed training regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. 3.) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances		the purposes of maintenance and cleaning. All current kitchen staff in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all kitchen staff were trained on the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** All staff educated on the need to ensure that all inspections/cleanings is on file for the kitchen hood exhaust systems and on the approved method for returning cooking appliances to where they were under the kitchen hood extinguishing equipment when the cooking appliances are moved for the purposes of maintenance and cleaning. · ·All kitchen staff were educated on the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Maintenance/designee will audit all kitchen hood inspections 1x monthly x6 months to ensure all inspections/cleanings is on file for the kitchen hood exhaust systems and that kitchen staff are properly educated on the proper	

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	requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, cooking appliances including a gas burner stove and oven, located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, he was not aware of any method or procedure in place. 4.) Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states		use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** Maintenance/designee will complete audit tool to reflect all inspections/cleanings is on file for the kitchen hood exhaust systems and that kitchen staff are properly educated on the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment and that an approved method for returning cooking appliances to where they were under the kitchen hood extinguishing equipment when the cooking appliances are moved for the purposes of maintenance and cleaning is maintained. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue	

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	Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every six months. This deficient practice could affect kitchen staff. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no documentation was provided to show a semi-annual inspection of the kitchen fire suppression system. Based on record review an annual inspection of the kitchen fire suppression system was conducted on 05/14/2024; however, no documentation of a semi-annual inspection six months after the annual inspection was available for review. Based on interview at the time of record review, the Maintenance Director stated he was not aware of any documentation available or if an inspection had been completed. These findings were reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in	K 0346	**K 346 Fire Alarm System - Out of Service** **What corrective action will be accomplished for those residents found to have been affected by the deficient**	03/14/2025

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	accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, the fire watch plan failed to: 1.) include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. 2.) include the person assigned to fire watch can have no other duties assigned. Based on interview during the record review, the Maintenance Director stated he had not reviewed the plan but stated a revision of the plan was in progress. 3.1-19(b)		**practice?** Fire Watch plan includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method and includes the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes that the person assigned to fire watch has no other duties assigned. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure our policy and procedures include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes that the person assigned to fire watch has no other duties assigned **What measures will be put into**	

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			place or what systematic changes will you make to ensure that the deficient practices do not recur? ·All staff educated on the need to ensure that our fire watch includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes that the person assigned to fire watch has no other duties assigned Maintenance/designee will audit our policies 1x monthly x6 months to ensure contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov is the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes that the person assigned to fire watch has no other duties assigned **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?**	

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			·Maintenance/designee will complete audit tool to reflect ensure that contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov is the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes that the person assigned to fire watch has no other duties assigned ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review 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 5.1.2 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	K 0353	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** **K 353 Sprinkler System - Maintenance and Testing** **What corrective action will be accomplished for those**	03/14/2025

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	components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, monthly inspection documentation for all sprinkler system control valves for 12 of 12 months was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged monthly sprinkler system control valve inspection documentation was not available for review. 3.1-19(b)		**residents found to have been affected by the deficient practice?** Monthly inspection documentation for all sprinkler system control valves for 12 of 12 months are available for review. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure monthly inspection documentation for all sprinkler system control valves for 12 of 12 months are available for review **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that all monthly inspection documentation for all sprinkler system control valves for 12 of 12 months available for review Maintenance/designee will audit inspection documentation for all sprinkler system control valves 1x monthly x6 months to ensure battery powered emergency lights were tested.	

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			How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place? ·Maintenance/designee will complete audit tool to reflect completed monthly inspection documentation for all sprinkler system control valves. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person	K 0354	**K 354 Sprinkler System - Out of Service** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Firewatch plan includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and	03/14/2025

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	should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, the fire watch plan failed to: 1.) include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. 2.) include the person assigned to fire watch can have no other duties assigned. Based on interview during the record review, the Maintenance Director stated he had not reviewed the plan but stated a revision of the plan was in progress. 3.1-19(b)		includes the person assigned to fire watch can have no other duties assigned. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure our Firewatch plan includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes the person assigned to fire watch can have no other duties assigned **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that our Firewatch plan includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH	

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			Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes the person assigned to fire watch can have no other duties assigned Maintenance/designee will audit all documentation for our Firewatch plan; that includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and includes the person assigned to fire watch can have no other duties assigned. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect ensure that our Firewatch plan includes contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to	

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			incidents@isdh.in.gov. and includes the person assigned to fire watch can have no other duties assigned ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on record review and interview, the facility failed to ensure portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, staff and visitors.	K 0355	**K 355 Portable Fire Extinguishers** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Annual fire extinguisher inspection documentation in place. Annual inspections that were conducted in the last year is available for review. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all	03/14/2025

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	Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, the maintenance director provided an annual fire extinguisher inspection document that was dated January of 2024. No documentation of an annual inspection conducted in the last year was available for review. Based on interview with the Maintenance Director, he stated the fire extinguishers received an annual inspection but was not able to provide documentation to show that the annual inspection had been completed in the last year. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		documentation for annual fire extinguisher inspections are in place. Annual inspections conducted in the last year is available for review. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that all annual fire extinguisher inspection documentation is in place, and that annual inspections were conducted in the last year is available for review. Maintenance/designee will audit annual fire inspection documentation 1x monthly x6 months to ensure that all annual fire extinguisher inspection documentation is in place, and that annual inspections are conducted. All documentation for last year is available for review. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect completed annual fire inspection documentation in place. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months,	

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			thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 110 resident room doors were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice could affect all residents, staff, and visitors in 1 of 4 smoke compartments. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, the corridor doors to resident rooms 202 and resident room 211 failed to latch after several attempts to close and latch the doors by the Maintenance Director at the time of observation. 3.1-19(b)	K 0363	**K 363 Corridor - Doors** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The corridor doors to resident rooms 202 and resident room 211 latch. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all corridor doors to resident rooms latch. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that all corridor doors to resident rooms latch. Maintenance/designee will audit 5 resident corridor doors 1x weekly x6 months to ensure that	03/14/2025

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			all corridor doors to resident rooms latch. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect all corridor doors to resident rooms are latching. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Based on observation, record review and interview, the facility failed to ensure 2 of 4 fuel fired water boilers had current certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, two gas fired boilers with a BTU	K 0500	**K 500 Building Services - Other** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Boiler certificate of inspection documentation is in place from the State of Indiana for review. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	03/14/2025

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	rating of 500,000 were in use located in the bolier mechanical room off of the employee service hall, providing domestic hot water to the facility but lacked Certificate of Inspection documentation from the State of Indiana for review. Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, state certificates from the Indiana Department of Homeland Security for the two water boilers were not provided. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all documentation is in place for the boiler inspection. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that all documentation is in place and available for review for the boiler inspections. Maintenance/designee will audit boiler inspection documentation 1x monthly x6 months to ensure that all documentation remains up-to-date and available for review. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect boiler certificate of inspection documentation is in place. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed,	

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			audit will continue.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric 1.) Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, the facility's emergency generators had a natural gas fuel source. The facility failed to provide a letter of reliability from NIPSCO, the	K 0511	**K 511 Utilities - Gas and Electric** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Letter of reliability from NIPSCO, the utility providing the natural gas on file. GFCI replaced in beauty shop and performing appropriately. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure the letter of reliability is on file and available upon request as well as GFCI's performing appropriately. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that the letter of reliability from NIPSCO is on file and that the GFCI's in the building are functioning appropriately.	03/14/2025

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	utility providing the natural gas. Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, two 200 kW natural gas generators were located in the rear of the facility. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 wet location in the beauty salon was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding		Maintenance/designee will audit documentation 1x monthly x6 months to ensure that the letter of reliability remains on file and that the updated documentation remains available for review and that GFCI's are working appropriately. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect letter of reliability documentation is in place and functioning GFCI's. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect residents, staff and visitors in the Beauty Salon. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, there was one electric receptacle			

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	within 2 feet of a sink in the Beauty Salon. A ground fault circuit interrupter (GFCI) type electrical receptacle was provided but failed trip when tested with a GFCI tester. The plastic covering of the GFCI receptacle also appeared to be physically damaged. Based on interview at the time of observation the Maintenance Director acknowledged the physical damage and acknowledged the receptacle failed to perform correctly when tested. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m.	K 0711	**K 711 Evacuation and Relocation Plan** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Facility's fire safety plan addresses the following items: a) Emergency phone call to fire department b) Isolation of fire. c) Preparation of floors and building for evacuation. d) Extinguishing. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the	03/14/2025

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	on 02/25/25, the facility's fire safety plan did not address the following items: a) Emergency phone call to fire department b) Isolation of fire. c) Preparation of floors and building for evacuation. d) Extinguishment of fire Based on interview at the time of record review, the Maintenance Director looked through the plan and stated the aforementioned items were not in the provided plan. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure the facility's fire safety plan addresses the following items: a) Emergency phone call to fire department b) Isolation of fire. c) Preparation of floors and building for evacuation. d) Extinguishing **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that the Facility's fire safety plan addresses the following items: a) Emergency phone call to fire department b) Isolation of fire. c) Preparation of floors and building for evacuation. d) Extinguish Maintenance/designee will audit documentation 1x monthly x6 months to ensure that the facility's fire safety plan addresses the following items: a) Emergency phone call to fire department b) Isolation of fire. c) Preparation of floors and building for evacuation. d) Extinguish **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect the	

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			facility's fire safety plan addresses the following items: a) Emergency phone call to fire department b) Isolation of fire. c) Preparation of floors and building for evacuation. d) Extinguishing process ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 4 of 12 shifts. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, there was no documentation for the following: 1. Third shift fire drill in the first quarter of 2024 or 2025 2. First shift fire drill in the second quarter of 2024 3. Third shift fire drill in the second quarter of 2024 4. third shift fire drill in the fourth quarter of 2024 At the time of record review, the Maintenance Director reviewed records documented in the "TELS" system but was not able to locate the	K 0712	**K 712 Fire Drills** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Facility fire drills conducted as required and are current. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure the facility's fire drills have been completed as required.	03/14/2025

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	missing fire drill documentation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		**What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that the Facility's fire drills are completed as required by ISDH. Maintenance/designee will audit documentation 1x monthly x6 months to ensure that the facility's fire drills are happening on schedule as required. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect the facility's compliance with fire drills being completed as required by ISDH. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, and interview, the facility failed to ensure annual inspection and testing of 3 of 3 oxygen storage and transfilling room fire door	K 0761	**K 761 Maintenance, Inspection & Testing - Doors** **What corrective action will be**	03/14/2025

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	assemblies was completed. LSC 19.3.2.4 states medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. 8.7.1.1 states protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.3 8.3.3.1 states 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, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 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. 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		**accomplished for those residents found to have been affected by the deficient practice?** Documentation of annual inspection of the oxygen storage and transfilling room and fire door assemblies is available for review. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure the facility's documentation of annual inspection of the oxygen storage and transfilling room and fire door assemblies completed. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·Maintenance educated on the need to ensure that the Facility's documentation of annual inspection of the oxygen storage and transfilling room and fire door assemblies is completed. Maintenance/designee will audit documentation 1x monthly x6 months to ensure that the facility's documentation of annual inspection of the oxygen storage	

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	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 all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m. on 02/25/25, no documentation of annual inspection of the oxygen storage and transfilling room fire door assemblies was available for review. Based on interview at the time of record review, the Maintenance Director provided a map of the facility with the doors that were inspected. The map with highlighted locations showed smoke compartment doors in the corridors of the facility. The Maintenance Director also stated an annual inspection was not conducted for the		and transfilling room and fire door assemblies is completed. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect the facility's compliance of documentation of annual inspection of the oxygen storage and transfilling room and fire door assemblies completed. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	oxygen storage and transfilling room fire door assemblies. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure flexible cords and adapters were not used as a substitute for fixed wiring in 2 of 4 smoke compartments. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 staff members working in the social services office. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, an extension cord was found powering a computer in the Social Services office. The Maintenance Director acknowledged the improper use of the extension cord at the time of observation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0920	**K 920 Electrical Equipment - Power Cords and Extens** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Extension cord removed from Social Service office. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure the facility was free from extension cords **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that the facility is free	03/14/2025

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			from extension cords Maintenance/designee will audit 5 areas of the building 1x weekly x6 months to ensure that the facility is free from extension cords **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect the facility's compliance with being free of extension cords. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0923 SS=F Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure full and empty oxygen cylinders were separated in 3 of 3 oxygen storage and transfilling rooms. This deficient practice could affect all residents and staff. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, the oxygen storage and transfilling rooms in the B, C, and D-wings contained full and	K 0923	**K 923 Gas Equipment - Cylinder and Container Storage** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Oxygen cylinders were separated and marked as full and/or empty. No ill effect due to alleged deficient practice. **How will you identify other**	03/14/2025

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	empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Maintenance Director acknowledged the cylinders were not marked as full and empty. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure the facility separated oxygen cylinders and marked them as full/empty. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that oxygen cylinders aren't mixed together and that they are marked as full or empty. Maintenance/designee will audit all oxygen rooms in the building 5x weekly x6 months to ensure that the facility is separating oxygen cylinders and marking them as full/empty. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·Maintenance/designee will complete audit tool to reflect the facility's compliance with oxygen cylinders. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months,	

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			thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	