STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155207	A. BUILDING -- B. WING	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

(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: 03/05/25. Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Emergency Preparedness survey, Majestic Care of New Haven was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 120 and had a census of 69 at the time of this survey. Quality Review completed on 03/06/25	E 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. **The facility is requesting a Paper Compliance review.**	
E 0037 SS=C 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 and testing 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; (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	E 0037	1 Immediate action(s) taken for the resident(s) found to have been affected include: No residents were found to be affected by this deficient practice. All staff were in-serviced regarding the facility policy for Emergency Preparedness, including RACE and PASS, with return demonstration knowledge of the training. 2 Identification of other residents having the potential to be affected was accomplished by:	03/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorri Maples	Administrator	03/20/2025

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	all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 03/05/25 at 10:11 a.m., annual EPP staff training was conducted on 05/22/24, but no documentation was available for review to show if staff could demonstrate knowledge of the EPP training. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated the EPP training was conducted within the last year but demonstration of knowledge for staff was not conducted. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		The facility has determined that all residents have the potential to be affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All staff were in-serviced regarding the facility policy for Emergency Preparedness, including RACE and PASS, with return demonstration knowledge of the training. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The maintenance director completed the in-service with all staff for the EPP training and return demonstration knowledge. Anyone not passing the return demonstration was reeducated to ensure knowledge of the EPP training and demonstrate as evidence. The maintenance director will incorporate this training in the weekly orientation of new hires that includes return demonstration. Anyone not passing the return demonstration will be reeducated to ensure knowledge of the EPP training and demonstrate as evidenced. Inservice/orientation records will be reviewed by the Safety Committee/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined	

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			by the committee.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/05/25 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Life Safety Code survey, Majestic Care of Haven Center 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility is partially protected by a Type II EES 60KW diesel powered generator. The facility has a capacity of 120 and had a census of 69 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered which the exception of a detached building housing the	K 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. **The facility is requesting a Paper Compliance review.**	

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	emergency generator and used for storage of maintenance equipment. Quality Review completed on 03/06/25			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain latching hardware on 1 of 5 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect 30 residents in two smoke compartments Findings include: Based on observation with the Maintenance Director on 03/05/25 at 11:50 a.m., the set of smoke barrier doors by room 108 was provided with latching hardware but failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the smoke doors were equipped with latching devices, and the doors did not properly latch when tested. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0100	1 Immediate action(s) taken for the resident(s) found to have been affected include: Fire door vendor was called in to inspect smoke barrier doors by room 108. The problem was found and corrected at the time of service. 2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Maintenance was in-serviced by the Administrator to perform weekly/monthly preventative maintenance checks on all smoke barrier doors to ensure they remain in good working order at all times. Fire door vendor was called in to inspect smoke barrier doors by room 108. The problem was found and corrected at time of service. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:**	03/10/2025

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			The maintenance director will complete weekly maintenance checks of smoke barrier doors for six (6) months, to ensure they are in good working order. Any door found not to latch into the frames, will be fixed immediately. Preventative maintenance checks will be performed monthly thereafter. Weekly maintenance checks/documentation will be reviewed by the monthly Safety Committee/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors (#1) Based on observation and Interview, the facility failed to ensure 1 of 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.	K 0222	1 Immediate action(s) taken for the resident(s) found to have been affected include: 1 The delayed egress on the front door is scheduled to be corrected/completed on 3/21/25. 2 A. The north exit door to the courtyard now has a code posted B. The courtyard gate in the courtyard exit now has a new lock and will release when the combination is entered. 2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be	03/21/2025

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	(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (#2) Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 courtyard exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. The deficient practices could affect 40 residents evacuating two smoke compartments. Findings include: Based on observation with the Maintenance Director on 03/05/25 between 11:20 a.m. and 12:30 p.m., The following was observed: (#1) The front exit door was equipped with a 15-second delayed egress. When the exit door was tested the irreversible process to release the lock was not initiated. Based on an interview at the time of observation, the Maintenance Director tried three times to activate the delayed egress and stated the delayed egress was not working and will need to be repaired. (#2) (a.) The north exit door that led into the courtyard exit was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad or by using a key FOB, but the code was not posted by the access control pad and only staff		affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** 1. The delayed egress on the front door is scheduled to be corrected/completed on 3/21/25. 2. A. The north exit door to the courtyard now has a code posted B. The courtyard gate in the courtyard exit now has a new lock and will release when combination is entered. Staff was in-serviced on the new combination lock and location of code for the courtyard. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The maintenance director will complete a weekly test of all delayed egress doors to ensure all are in working order, for 6 months. After the 6 months, checking delayed egress doors will be placed on the preventative maintenance program for monthly checks. Any door that fails testing will be immediately corrected. The maintenance director will do a weekly check of the combination lock on the courtyard gate to ensure it remains in good working condition. After the 6 months, checking the lock will be placed on the preventative maintenance program for monthly checks. The lock will be immediately changed should it fail to open upon entering	

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	carried a key FOB. Based on an interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad and only staff carried a key FOB. (#2) (b.) The courtyard gate in the courtyard exit discharge was locked with a padlock and a combination is used to unlock the padlock and open the gate, but when the combination was entered the padlock did not unlock. The Maintenance Director had to find a lubricant (WD-40) to spray the padlock. The padlock unlocked after the WD-40 was applied. Based on an interview at the time of observation, the Maintenance Director agreed the pad lock would not open on the first try and took 10 minutes to unlock the pad lock. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		the combination. Audit records will be reviewed by the Safety Committee/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 3 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff by the service hall exit. Findings include: Based on observation with the Maintenance Director on 03/05/25 at 12:28 p.m., in the staff smoking area outside the employee exit by the	K 0741	1 Immediate action(s) taken for the resident(s) found to have been affected include: The cigarette butts found in the staff smoke area were cleaned up immediately. 2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.	03/06/2025

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	generator which contained a noncombustible container with a self-closing cover, had over 35 cigarette butts disposed on the ground inside and outside of the staff smoking area. Based on an interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground in the staff smoking area. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Maintenance was in-serviced on ensuring all smoke areas are checked for cleanliness and safety weekly. All staff were in-serviced on ensuring that cigarette butts are disposed of in the noncombustible container provided in the smoke areas. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The maintenance director will complete weekly checks for 6 months, of all smoke areas to ensure butts are disposed of properly in the noncombustible containers. The rounds will then be placed on the Preventative Maintenance program to check smoke areas monthly for continued compliance. Audit records will be reviewed by the Safety Committee/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 1 of 9 corridor doors in the dining room smoke compartment covered by decorations	K 0753	1 Immediate action(s) taken for the resident(s) found to have been affected include:	03/10/2025

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	did not exceed 30 percent of the door. LSC 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with		All decorations/items on the activity door were removed. 2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** The decorations/items were removed from the activity door. The activity staff were in-serviced regarding not hanging combustible paper decorations/items on any corridor doors. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The maintenance supervisor will complete weekly rounds for 6 months to ensure corridor doors do not have combustible items attached to them. Rounds will then be monthly thereafter to ensure continued compliance. Records will be reviewed by the Safety Committee/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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	Section 9.7. This deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on an observation with the Maintenance Director on 03/05/25 at 12:51 p.m., the activities room door had paper clover leaves covering 90% of the door. Based on interview at the time of the observation, the Maintenance Director agreed the corridor door was covered with combustible decorations and stated the decorations will be removed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			