STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155143	A. BUILDING -- B. WING	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/23 Facility Number: 000067 Provider Number: 155143 AIM Number: 100267880 At this Emergency Preparedness survey Majestic Care of Terre Haute was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 104 certified beds. At the time of the survey, the census was 75. Quality Review completed on 07/19/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/23 Facility Number: 000067 Provider Number: 155143 AIM Number: 100267880 At this Life Safety Code survey, Majestic Care of Terre Haute was found not in compliance with	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during a Life Safety Survey with exit on 07/18/23. Please accept this Plan of Correction as the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wendy McNamara Baker	HFA	08/04/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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) and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was constructed in 1972 and determined to be of Type V (000) construction and was fully sprinklered. There was a dining room addition added in 2014 and a storage room addition constructed in 2015. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 104 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered. Quality Review completed on 07/19/23		provider's credible allegation of compliance as of August 10, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 9 hazardous areas, such as combustible storage rooms over 50 square feet were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect as many as 10 staff in the service hall compartment. Findings include: Based on observation with the Executive Director and Maintenance Director during a tour of the facility at 12:19 p.m. on 07/18/23, the corridor door to the Central Supply room across the hall from the Laundry Room was equipped with a self-closing device but the door failed to fully	K 0321	It is the responsibility of the facility to ensure that storage areas are provided with a self-closing device which would cause the doors to automatically close and latch into door frames. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The central supply room door has been adjusted to allow it	07/21/2023

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	close and latch into the door frame when tested three separate times. Based on interview at the time of observation, the Maintenance Director agreed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		to fully latch into the door frame when closed. . All other doors were audited and maintained as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Full audit of all corridor doors in the facility were observed, doors that needed to be adjusted were to assure they fully latched into the door frames. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will tour bldg monthly for 6 months to assure rooms that doors latch positively into the door frames. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 07/18/23 at 12:12 p.m., there were two spare sprinkler cabinets in the riser room but there	K 0353	It is the responsibility of the facility to ensure that the spare sprinkler cabinet is equipped and maintained. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. Two sidewall sprinkler heads were added to the spare sprinkler cabinet. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance director was reeducated on missing items. Two sidewall sprinklers were added to	07/28/2023

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	were no sidewall spare sprinklers in the cabinets. Based on interview at the time of the observation, the Maintenance Director confirmed the spare sprinkler cabinet did not contain any spare sidewall sprinklers. During a tour of the facility with the Executive Director and Maintenance Director on 07/18/23, sidewall spare sprinklers were observed in the facillity. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		the cabinet. Our contracted sprinkler system company was contacted and educated on the missing items located in the cabinet and to assure this will be on all further inspections. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or designee will tour bldg monthly for 6 months to assure rooms that doors latch positively into the door frames. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 2 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0918	It is the practice of this facility to have a written record of weekly inspections for the generator. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. **What measures will be put into**	07/21/2023

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	Based on record review with the Executive Director and Maintenance Director on 07/18/23 from 9:40 a.m. to 11:40 a.m., documentation for the weeks of 11/14/22 and 11/28/22 weekly generator testing was not available for review. Based on an interview at the time of record review, the Maintenance Director confirmed that documentation for weekly generator testing of the aforementioned weeks was not available for review at the time of the survey. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance director was re educated on weekly written inspections on generators. If maintenance director out of facility a back up will complete weekly written inspections. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be conducted monthly with the quality assurance committee to assure that the Emergency Generator has weekly written documentation and is completed at the time of testing. Documentation of these tests will be reviewed by the quality assurance committee. Executive Director to oversee.	