STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155243	A. BUILDING -- B. WING	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

(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: 11/21/24 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 At this Emergency Preparedness survey, Majestic Care of Lafayette was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 122 certified beds. At the time of the survey, the census was 81. Quality Review completed on 11/25/24	E 0000	Majestic Care of Lafayette requests a desk review of the enclosed plan of correction.	
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: 11/21/24 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 At this Life Safety Code survey, Majestic Care of Lafayette was found not in compliance with	K 0000	Majestic Care of Lafayette requests a desk review of the enclosed plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian	Lessley	12/11/2024

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

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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), 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, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 81 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for two detached storage garages which were used to store maintenance equipment, that were not sprinklered. Quality Review completed on 11/25/24			
K 0346 SS=C 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 accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Director of	K 0346	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The fire watch plan was amended by the Maintenance Director to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method as well as	11/22/2024

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	155243	A. BUILDING 01 B. WING	11/21/2024

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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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	Maintenance on 11/21/24 at 2:15 p.m., the fire watch plan stated to contact the department of health but failed to 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. Also, the fire watch plan stated to contact the fire department, insurance carrier, facility operator, and monitoring company but the space to list phone numbers was blank. Based on interview during the record review, the Director of Maintenance confirmed the fire watch documentation contact information was missing from the form. This finding was reviewed with the Director of Maintenance and the Executive Director at the exit conference. 3.1-19(b)		completing the Incident reporting form and e-mailing it to incidents@isdh.in.gov as a secondary method. A copy of the incident report form was included with the instruction to report. The fire watch plan was updated with accurate phone numbers for the local fire department, insurance carrier, facility operator and the monitoring company. These changes were immediately added to the Emergency Preparedness Binder by the Maintenance Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the practice. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director was educated on K346 Fire Alarm System out of Service by the Administrator. The emergency preparedness binder will be reviewed quarterly for accuracy and completeness by the maintenance director and executive director or designee **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur:**	

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			Review of the emergency preparedness binder will occur quarterly for one year as part of the monthly QAPI meeting.	
K 0354 SS=C 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 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 occupants in the facility. Findings include: Based on records review with the Director of Maintenance on 11/21/24 at 2:15 p.m., the fire watch plan stated to contact the department of health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary	K 0354	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The fire watch plan was amended by the Maintenance Director to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method as well as completing the Incident reporting form and e-mailing it to incidents@isdh.in.gov as a secondary method. A copy of the incident report form was included with the instruction to report. The fire watch plan was updated with accurate phone numbers for the local fire department, insurance carrier, facility operator and the monitoring company. These changes were immediately added to the Emergency Preparedness Binder by the Maintenance Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	11/22/2024

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	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. Also, the fire watch plan stated to contact the fire department, insurance carrier, facility operator, and monitoring company but the space to list phone numbers was blank. Based on interview during the record review, the Director of Maintenance confirmed the fire watch documentation contact information was missing from the form. The finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)		All residents have the potential to be affected by the practice. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director was educated on K346 Fire Alarm System out of Service by the Administrator. The emergency preparedness binder will be reviewed quarterly for accuracy and completeness by the maintenance director and executive director or designee **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur:** Review of the emergency preparedness binder will occur quarterly for one year as part of the monthly QAPI meeting.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 40 residents, 6 staff, and 2 visitors.	K 0372	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** An adjustment was made to the hydraulic closer for the set of fire barrier doors nearest to the Activities room, such that doors functioned correctly and closed in their proper position. **How other residents having the**	11/22/2024

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	Findings include: Based on observations made during a tour of the facility with the Director of Maintenance and Executive Director on 11/21/24 at 3:10 p.m., the set of fire barrier doors nearest to the Activities room had a one-inch gap along the center where the doors came together in the closed position. This was verified by the Director of Maintenance at the time of observation and would on the doors to get them to fully close as soon as possible.\par This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the practice. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director was educated on K372 Subdivision of Building Spaces – Smoke Barrier Construction. Inspection of fire barrier corridor doors for proper functioning will be performed weekly by the maintenance director or designee for 1 month and monthly thereafter, recorded in the TELS system **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur:** The results of the fire barrier corridor door inspections will be reviewed each month in the monthly QAPI meeting for 6 months and quarterly thereafter.	