STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING -- B. WING	09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(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: 09/11/23 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Emergency Preparedness survey, Majestic Care of South Bend was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 103 certified beds. At the time of the survey, the census was 89. Quality Review completed on 09/13/23	E 0000	This plan of correction is submitted as required under federal and state regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate. That the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied immediately. The facility	
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: 09/11/23 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Life Safety Code survey, Majestic Care of South Bend was found not in compliance with	K 0000	This plan of correction is submitted as required under federal and state regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate. That	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Cox	Executive	09/29/2023

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), 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, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 103 and had a census of 89 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/13/23		the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied immediately. The facility	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 16 exit signs was continuously illuminated. This deficient practice could affect approximately 20 residents and staff while using the Main Dining area.	K 0293	1. No residents were harmed by the alleged deficient practice. The identified exit sign identified in the survey has been replaced and it is functioning properly.	09/13/2023

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MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	Findings include: Based on observations on 09/11/23 during a tour of the facility from 2:28 p.m. to 4:42 p.m. with the Maintenance Director, the emergency exit sign in the Main Dining area was not illuminated. Based on an interview with the Maintenance Director at the time of observation, it was stated the exit sign light was not working properly and would need to be replaced. Findings were discussed with the Maintenance Director at exit conference. 3.1.19(b)		2. All exit signs were reviewed and no further issues were observed. 3. Maintenace Director was in-serviced by the Executive Director on exit light locations and functionality. 4. Maintenance Director and/or designee will conduct audit weekly x 4 weeks, monthly x 2 months, and quarterly x 3 quarters to ensure all exit signs are functioning properly. Results of audits will be reviewed at the monthly QAPI meeting.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.			

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	18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semi-annually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states 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 lease every six months. This deficient practice could affect staff in the kitchen and approximately 15 residents in the dining room. Findings include: Based on records review with the Maintenance Director on 09/11/23 between 9:30 a.m. and 2:01 p.m., kitchen suppression system documentation dated 02/07/23 and 08/07/23 both stated within the inspection report that when the suppression system was activated, electrical components turned off, but the exhaust fans failed to turn on and did not work when tested. Based on interview at the time of record review, the Maintenance Director confirmed that the exhaust fan has not been working for awhile now and the facility is waiting on available parts to be able to fix the issue. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)	K 0324	1. The fire suppression hood identified during the survey was repaired. No resident was harmed by this alleged deficient practice. 2. No other residents were harmed by this alleged deficient practice. 3. Maintenance Director was in-serviced by the Executive Director on the operation of the fire suppression hood. 4. Maintenance Director and/or designee will conduct audits on the fire suppression hood monthly x 6 months and quarterly x 3 quarters to ensure compliance. Results of the audits will be discussed at monthly QAPI meeting.	09/27/2023

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K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide 1 of 1 correct 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 record review with the Maintenance Director on 09/11/23 between 9:30 a.m. and 2:05 p.m., two different fire watch policies were produced. One was titled "Fire Watch" and another was titled "Loss of Fire/Life Safety Systems." Both policies had missing information. The document titled "Fire Watch" did not address that fire watch duties should be conducted at least every 15 minutes, plus the plan 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. Furthermore, the document listed "Loss of Fire/Life Safety	K 0346	1. No residents were harmed by the alleged deficient practice. The Fire Watch Policy has been revised to include that the fire watch duties will be conducted every 15 minutes. In addition, the information for contacting IDoH has been added to the Fire Watch Policy - the Indiana Department of Health ISDH Gateway link and the secondary method for contacting the ISDH, incidents@isdh.in.gov. 2. No other residents were harmed by the alleged deficient practice. 3. The Maintenance Director was in-serviced by the Executive Director on the Fire Watch Policy. 4. The Maintenace Director and/or designee will audit the Fire Watch policy weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters to ensure compliance. Audits will be reviewed at the monthly QAPI meeting.	09/25/2023

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	Systems/Fire Walk" also did not address contact information listed above. Based on interview at the time of record review, the Maintenance Director agreed that two different fire watch policies were present and agreed there was confusion on which was the correct policy. Furthermore, he acknowledged the missing information on the documents. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)			
K 0353 SS=F 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. 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 record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the	K 0353	1. The internal pipe flush is scheduled. No residents were harmed by this alleged deficient practice.	09/29/2023

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	Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of sprinkler system inspection report on 09/11/23 between 9:30 a.m. and 2:05 p.m. with the Maintenance Director present, the Internal Pipe Inspection report dated 08/04/22 stated "Found lots of rust scale in dry pipe system. Recommend that dry pipe fire sprinkler system be flushed." Based on interview at the time of record review, the Maintenance Director stated that he was unaware if the flush for the dry pipe system had a flush conducted. During a phone call with the sprinkler company, they had confirmed that a quote had originally been sent to the facility to conduct a flush and stated the flush still had not been completed yet. This finding was reviewed with the Maintenance Director at the exit conference. 3-1.19(b)		2. No residents were harmed by this alleged deficient practice. 3. The Maintenance Director was in-serviced by the Executive Director on the 5 year Internal Sprinkler Inspection. 4. The Maintenance Director and/or designee will audit the sprinkler system inspections annually to ensure compliance. The results of the audits will be reviewed at the Monthly QAPI meeting.	

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K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) 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	K 0354	1. No residents were harmed by the alleged deficient practice. The Fire Watch Policy has been revised to include that the fire watch duties will be conducted every 15 minutes. In addition, the information for contacting IDoH has been added to the Fire Watch Policy - the Indiana Department of Health ISDH Gateway link and the secondary method for contacting the ISDH, incidents@isdh.in.gov. 2. No other residents were harmed by the alleged deficient practice. 3. The Maintenance Director was in-serviced by the Executive Director on the Fire Watch Policy. 4. The Maintenace Director and/or	09/25/2023

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	facility. Findings include: Based on record review with the Maintenance Director on 09/11/23 between 9:30 a.m. and 2:05 p.m., two different fire watch policies were produced. One was titled "Fire Watch" and another was titled "Loss of Fire/Life Safety Systems." Both policies had missing information. The document titled "Fire Watch" did not address that fire watch duties should be conducted at least every 15 minutes nor the plan 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. Furthermore, the document listed "Loss of Fire/Life Safety Systems/Fire Walk" also did not address contact information listed above. Based on interview at the time of record review, the Maintenance Director agreed that two different fire watch policies were present and agreed there was confusion on which was the correct policy. Furthermore, he acknowledged the missing information on the documents. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)		designee will audit the Fire Watch policy weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters to ensure compliance. Audits will be reviewed at the monthly QAPI meeting.	
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

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	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 8 of 20 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient	K 0355	1. All fire extinguishers identified during the survey have been inspected dated and signed according to the company policy. No residents were harmed by the alleged deficient practice. 2.No other residents were harmed by the alleged deficient practice. 3. The Maintenance Director was in-serviced by the Executive Director on monthly Fire Extinguisher inspection. 4. The Maintenance Director and/or designee will audit the fire extinguishers weekly x 4 weeks, monthly x 3 months, and quarterly x 3 quarters to ensure compliance. Results of the audits will be reviewed at monthly QAPI meeting.	09/15/2023

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	practice could affect approximately all residents, staff and visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., the following fire extinguishers were observed to have missing inspections for the months of June, July and August of 2023: a) One K-class and one ABC located in the physical therapy office b) One ABC extinguisher located in the smoking area c) Two ABC extinguishers located in the Mechanical Room d) Two ABC extinguishers located in the Laundry Room e) One ABC extinguisher located in the Beauty Salon Based on interview at the time of observations, the Maintenance Director stated that he was unaware of the missed monthly inspections and acknowledged he had missed the aforementioned fire extinguishers. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material			

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	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 2 storage room corridor doors on the South Hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist	K 0363	1. The door knob and latch was installed on the South Hall Corridor door. No residents were harmed by the alleged deficient practice.	09/15/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(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
	the passage of smoke. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., the corridor door to the South Hall storage room in the corridor did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame and would have to be fixed. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		2. No other doors were identified as not working appropriately. No other residents were harmed by the alleged practice. 3. The Maintenance Director was in-serviced by the Executive Director on proper working door requirements. 4. The Maintenance Director and/or designee will audit 5 doors weekly x 4 weeks, monthly x 2 months, and quarterly x 3 quarters to ensure compliance. Results of the audits will be reviewed at the monthly QAPI meeting.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.			

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MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 smoking area was maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 10 staff and residents near the ambulance entrance. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., in the courtyard resident smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Furthermore, trash was observed in the cigarette butt discard container. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0741	1. Metal containers with self-closing covers and including ashtrays have been purchased and put into service in the areas identified during the survey. No residents were harmed by this alleged deficient practice. 2. All smoking areas were observed and no other issues were noted. No other residents were harmed by this alleged deficient practice. 3. The Maintenance Director was in-serviced by the Executive Director on appropriate smoking containers needed. 4. The Maintenance Director and/or designee will conduct audits weekly x 4 weeks, monthly x 2 months, and quarterly x 3 quarters to ensure compliance. Audits will be reviewed at monthly QAPI meeting.	09/20/2023
K 0761 SS=F				

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MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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Bldg. 01	1. Based on record review, observation, and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires 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. This deficient practice could affect approximately 5 staff in the kitchen and an unknown number of residents. Findings include: Based on record review with the Maintenance Director on 09/11/23 between 09:30 a.m. and 2:05 p.m., no documentation could be located for testing of the rolling fire/window door used for the kitchen. Based on observation during a tour of the facility between 2:28 p.m. and 4:42 p.m., a fire/window drop down door was observed that separates the service hall and the kitchen. Based on interview at the time of record review and interview, the Maintenance Director confirmed the drop down door and acknowledged no inspection documentation for the drop down door could be found during the survey. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)	K 0761	1. The rolling door identified during the survey has been repaired and functions properly. No residents were harmed by the alleged deficient practice. 2. No other rolling doors are in the facility. No other residents were harmed by the alleged. deficient practice. 3. The Maintenance Director was in-serviced by the Executive Director on proper operation of the rolling fire door. 4. The Maintenance Director and/or designee will audit the rolling fire door monthly x 6 months and quarterly x 3 quarters to ensure compliance. Results of the audits will be reviewed and monthly QAPI meeting.	09/29/2023

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MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	2. Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 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, 5.2.4.1 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 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			

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	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. Findings include: Based on record review with the Maintenance Director on 09/11/23 between 09:30 a.m. and 2:06 p.m., no documentation of an annual inspection for the (5) fire door assemblies was available for review. Based on observation during the tour between 11:50 a.m. and 1:00 p.m., there were (4) fire rated smoke barrier separation door assemblies and one oxygen storage/transfilling room. Furthermore, a monthly inspection listed as "Fire Doors: Fire Doors" had been completed on an online program 'TELS' on 04/28/23, but did not include a list of the doors inspection and did not include the necessary requirements inspection to determine if a proper fire door inspection was conducted. Based on interview at the time of record review, the Maintenance Director stated that they were unaware if a fire door inspection had been completed within the past year and agreed no other documentation could be located to confirm a proper fire door inspection was conducted within the last 12 months. Findings were discussed with the Maintenance Director at exit conference.			

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	3.1-19(b)			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, record review and interview, the facility failure to ensure 1 of 1 portable space heater was not used in the facility. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., a portable space heater was observed in the closet of the business office adjacent to the main lobby area. During record review between 09:30 a.m. and 2:05 p.m., no space heater policy was provided. Based on interview at the time of the observation, the Maintenance Director stated that space heaters are not permitted anywhere in the facility and acknowledged that there was a space heater. Findings were discussed with the Maintenance Director at exit conference.	K 0781	1. The portable space heater identified during the survey has been removed from the facility. No residents were harmed due to this alleged deficient practice. 2. A review was completed and no other space heaters were found. No other residents were harmed due to this alleged deficient practice. 3. The Maintenance Director was in-serviced by the ED regarding use of space heaters not allowed in the facility. 4. The Maintenance Director will complete a review of the facility weekly x 4 weeks, monthly x 2 months, and quarterly x 3 quarters to ensure compliance. Results of the audits will be reviewed during monthly QAPI meeting.	09/13/2023
	3.1-19(b)			
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 4 of 4 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 6 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/12/23	K 0920	1. The power cords and the extension cords identified during the survey have been removed from the facility. No residents were harmed by the alleged deficient practice. 2. All unapproved power cords and extension cords were removed from the facility. No other residents were harmed by the alleged practice. 3. The Maintenance Director was	09/15/2023

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	between 2:28 p.m. and 4:42 p.m., the following findings were noted: a) A power strip was used to supply power to a microwave (high power draw equipment) and coffee maker (high power draw equipment) in the Business Office. b) A power strip was used to power a refrigerator (high power draw equipment) in the Nursing Directors Office. c) A power strip was used to power a microwave (high power draw equipment) in the Activities Office d) A power strip was used to power a refrigerator (high power draw equipment) in the pantry room near the 100 nursing station Based on interview at the time of observations, the Maintenance Director acknowledged the aforementioned issues and removed the power strips at each location. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord was not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., a coffee pot (high power draw equipment) was being supplied power		in-serviced by the Executive Director on use of power and extension cords in the facility. 4. The Maintenance Director and/or designee will conduct audits weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters to ensure compliance. The audits will be reviewed during the monthly QAPI meeting.	

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	by an extension cord in the employee break room. Based on interview at the time of observation, the Maintenance Director acknowledged the extension cord and removed the cord upon observation. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord was installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., under a table top in the Laundry Room, a power strip was plugged into another power strip that was used to power a fan. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned issue and unplugged one of the power strips. This finding was reviewed with the Maintenance Director during the exit conference.			

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	3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a			

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	threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure oxygen cylinders of nonflammable gases such as oxygen in 2 of 2 transfilling/storage rooms were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect approximately 25 staff and residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/11/23 between 2:28 p.m. and 4:42 p.m., seven 'E' type oxygen cylinders in both the 200 and 100 wings were standing upright on the floor of the oxygen storage/trans-filling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged two 'E' type oxygen cylinders in the oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. The cylinders were fixed and secured upon observation. The finding was reviewed with the Maintenance	K 0923	1.The Oxygen cylinders identified in the survey have been secured. No residents have been harmed by this alleged deficient practice. 2. All other Oxygen cylinders were reviewed, and no further issues were observed. No other residents were harmed by this alleged deficient practice. 3. The Maintenance Director was in-service by the Executive Director on proper storage of Oxygen cylinders. 4. The Maintenance Director and/or designee will conduct audits weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters to ensure compliance. The results of the audits will be reviewed during monthly QAPI meeting.	09/27/2023

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	Director during the exit conference. 3.1-19(b)			