STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 01 B. WING	10/26/2023

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

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K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/11/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 10/26/23 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 At this Life Safety Code PSR, Majestic Care of South Bend was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, 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 78 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 10/30/23	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth**in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests a Post **Survey Desk Review. The facility is also requesting a temporary waiver of tag F-353. The waiver and supporting documentation is attached.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rayne Wise	Executive Director	11/28/2023

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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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 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,	K 0353	The facility will continue to ensure the sprinkler system operates as designed, receives an unobstructed flow of water, and is maintained accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. With evidence of the presence of sufficient material to potentially obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. The facility will ensure issues are addressed promptly when identified. Inspection, test, and maintenance records will be available for review. Ongoing, the	06/14/2024

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	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 10/26/23 between 09:51 a.m. and 10:27 a.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 observation, the Maintenance Director stated that the flush has been scheduled to be completed, however the flush has not been conducted as of the time of the survey. This finding was reviewed with the Maintenance Director at the exit conference. This deficiency was cited on 09/11/23. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3-1.19(b)		Administrator or designee will monitor the sprinkler system inspection, tests, and maintenance documentation to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. The sprinkler system flush began on 11.9.23. Please see the attached letter and Work Order. The facility is submitting with the POC a Temporary Waiver Request for this citation. The weather will not be favorable enough to complete the flush until the Spring of 2024. The audits being conducted that sprinkler system is operational by the Maintenance Director and/or Designee will continue ongoing until completion.	
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			

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	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. (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 areas were 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 10/26/23 between 10:28 a.m. and 10:58 a.m., in the ambulance resident and staff smoking area there were five cigarette disposable containers that were self-closing, it was noted that a large amount of trash was located inside two of the containers which contained discarded cigarette butts. Furthermore, a plastic waste container was noted at the smoking area that contained large amounts of trash that had approximately 4 cigarette butts	K 0741	The facility will ensure smoking materials are discarded properly in areas where smoking is permitted. Ongoing, the Administrator or designee will monitor smoking areas to ensure proper disposal of discarded smoking materials to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. The facility has purchased receptacles that will allow for proper disposal smoking material, see attachment. The audits of the smoking area being clean and ashtrays free of flammable material will be	11/10/2023

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	and ash discarded in the waste container. Based on interview at the time of interview, the Maintenance Director confirmed there was trash in the cigarette bins and improperly discarded cigarette butts in the trash can at the smoking area. This finding was reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 09/11/23. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3.1-19(b)		conducted by the Maintenace Director and/or designee will continue ongoing until completion.	
K 0761 SS=F Bldg. 01	Based on record review, observation, and interview, the facility failed to maintain 1 of 1 rolling fire door in accordance with 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 10/26/23 between 09:51 a.m. and 10:27	K 0761	The facility will ensure fire door assemblies are in accordance with Chapter 5 of NFPA 80, *Standard for Fire Doors and Other Opening Protectives,* 2010 edition. Ongoing, the Administrator or designee will monitor documentation of maintenance, inspection, and testing of fire door assemblies to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. The facility had the Rolling Door serviced, see attached work order, and door is operational and compliant with NFPA standards. The audits to ensure that the	11/10/2023

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	a.m., documentation from the rolling fire door inspection for the drop down door was provided during the survey. Upon review of the inspection dated 10/24/23 from the inspection company, the company listed that the fire door failed inspection due to "cannot reset roll door due to a malfunction in the release/test box. Also, could not reset tension due to reset wheel not turning like it should." Based on observation during a tour of the facility between 10:28 a.m. and 10:56 a.m., a rolling fire door was noted in the window separating the service corridor and kitchen. Based on interview at the time of record review, the Maintenance Director stated that he was unaware of the deficiency on the most recent inspection and would contact the company to start the process to fix the door. Findings were discussed with the Maintenance Director at exit conference. This deficiency was cited on 09/11/23. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3.1-19(b)		Rolling Fire door being conducted by the Maintenance Director and/or designee will continue ongoing until completion.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and 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			

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	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 Based on observation and interview, the facility failed to ensure 2 of 2 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 10 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/26/23 between 10:28 a.m. and 10:58 a.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the 100 Hall pantry room near the nurse's desk. Also, a microwave located in the Activities Office was connected to and powered by an extension cord which was plugged into a power strip between the wall and the desk. Based on interview at the time of observation, the Maintenance Director stated that he had removed the cord from the Activities Office earlier during a survey but was unaware that an extension cord repowered the microwave.	K 0920	The facility will ensure compliance with power cord and extension cord requirements. Ongoing, the Administrator or designee will monitor the facility to ensure continued compliance with power cord and extension cord requirements. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. The facility has removed all extension cords and power strips that are not compliant with NFPA standards. The facility purchased, see attached invoice, power strips that are NFPA complaint with the UL1363. The audits to ensure that any extension cord or 6 way plugs meet the NFPA standards being conducted by the Maintenance Director and/or designee will	11/10/2023

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	Findings were discussed with the Maintenance Director at exit conference. This deficiency was cited on 09/11/23. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3.1-19(b)		continue ongoing until completion.	