STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155338	A. BUILDING -- B. WING	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

(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: 08/26/24 Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900 At this Emergency Preparedness survey, Majestic Care of Avon was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 140 certified beds. At the time of the survey, the census was 82. Quality Review completed on 08/29/24	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: 08/26/24 Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900 At this Life Safety Code survey, Majestic Care of Avon was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Huff	Administrator	09/09/2024

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), and 410 IAC 16.2. Building 0101, the original building, and Building 0202, which consisted of the Therapy Care Unit (TCU) wing, were surveyed using Chapter 19, Existing Health Care Occupancies. 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 and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 63 of 78 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 78 resident sleeping rooms. The facility has a capacity of 140 and had a census of 82 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/29/24			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained.	K 0353	/p> The Corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents. other residents that have	09/10/2024

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	Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of SafeCare documentation entitled "Sprinkler: Report of Inspection" documentation for the most recent twelve-month period with the Maintenance Director during record review from 8:54 a.m. to 11:30 a.m. on 08/26/24, weekly dry sprinkler system gauge inspection documentation for 5 weeks of the most recent 52-week period (January 1st 2024 through January 31st 2024) was not available for review. Monthly wet sprinkler system gauge inspection documentation for January, 2024 in the most recent 12-month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for the month of January, 2024 in the most recent 12-month period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review adding that the facility was without a		the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The sprinkler system was inspected on 8/27/24 and found no concerns. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Facility Maintenance Director was educated on K-353 Sprinkler System- Maintenance and Testing on 9/5/2024 by the Executive Director to ensure timely inspections and documentation of sprinkler system inspections in accordance with NFPA 25. How the corrective action will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: The Maintenance Director and/or designee will audit sprinkler system inspections insuring they are conducted in accordance with NFPA 25 for weekly and monthly inspections, and documentation available to review to the authority having jurisdiction upon request, 1x weekly x3 months, then 1x monthly for 3 months. Any negative findings will be	

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	Maintenance Director at that time. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		immediately remedied. All findings will be brought to the facility Quality Assurance Committee meeting for monitoring.	
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to inspect 32 of 32 portable fire extinguishers throughout 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	K 0355	K- 355 Portable Fire Extinguishers The Corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents. other residents that have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The 32 portable fire extinguishers were inspected on 8/27/24 and found no concerns. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility Maintenance Director was educated on K-355 Portable Fire Extinguisher inspections on 9/5/24 by the Executive Director.	09/10/2024

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	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 practice could affect all residents, as well as staff, and visitors in the facility. Findings include: Based on an observations made with the Maintenance Director during a tour of the facility on 08/26/24 at 1:06 p.m., the monthly inspection tag on all 32 of the fire portable extinguishers located throughout the facility lacked documentation of a monthly inspections for the months of: October of 2023, November of 2023 and December of 2023 as well as a monthly inspection for January of 2024. This was acknowledged by the Maintenance Director at the time of each aforementioned observation adding that he had only been working at the facility since February of 2024 and did not know what the Maintenance Director before he was hired did during that time. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		How the corrective action will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: The Maintenance Director and/or will audit Portable Fire Extinguishers inspections to insure they are conducted in accordance with K- 355, 1x weekly x3 months, then 1x monthly for 3 months. Any negative findings will be immediately remedied. All findings will be brought to the facility Quality Assurance Committee meeting for monitoring.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 4 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied	K 0712	K- 712 Fire Drills The Corrective action taken for	09/10/2024

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	conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the Direct Supply - TELS documentation entitled "Conduct a monthly fire drill" form with the Maintenance Director on 08/26/24 at 10:07 a.m., the following was noted: a) A fire drill conducted in the first quarter (January, February, and March) of 2024 on the third shift was not available for review. b) A fire drill conducted in the second quarter (April, May, and June) of 2024 on the third shift was not available for review. c) A fire drill conducted in the fourth quarter (October, November, and December) on the first, second, or third shifts in 2023 were not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned drills as not being available for review as of the time of this survey. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 3.1-51(c)		those residents found to be affected by the deficient practice includes: There are no identified residents. other residents that have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected, but none were identified. A fire drill will be conducted on 9/9/24 on each shift under varied conditions. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenace Director was educated on K-712 Fire Drills, by the Executive Director on 9/5/24 to ensure fire drills are conducted quarterly, on each shift under varied conditions. How the corrective action will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: The Maintenance Director and/or will audit Fire Drill inspections to insure they are conducted in accordance with K- 712, 1x	

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			weekly x3 months, then 1x monthly for 3 months. Any negative findings will be immediately remedied. All findings will be brought to the facility Quality Assurance Committee meeting for monitoring.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 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	K 0761	K- 761 Maintenance, Inspection and Testing – Doors The Corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents. other residents that have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The Oxygen Storage and Transfilling room door was inspected on 8/26/24 and found no concerns. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:	09/10/2024

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	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 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 occupants. Findings include: Based on record review with the Maintenance Director on 08/26/24 at 9:05 a.m., an annual inspection of the fire door assemblies was available for review, but the facility Oxygen Storage and Transfilling room door had not been inspected. Based on observations made during a tour of the facility at 1:40 p.m. the Oxygen Storage and Transfilling room was identified. Based on interview at the time of records review, the		The Maintenace Director was educated on K-761- Doors on 9/5/24 by the Executive Director to ensure annual inspections of fire doors assemblies are completed. How the corrective action will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: The Maintenance Director and/or will audit fire door assemblies to insure they are conducted in accordance with K- 761, 1x weekly x3 months, then 1x monthly for 3 months. Any negative findings will be immediately remedied. All findings will be brought to the facility Quality Assurance Committee meeting for monitoring.	

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	Maintenance Director stated an annual door inspection had been conducted and confirmed that they had omitted the Oxygen Storage and Transfilling room door in that inspection. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect any resident, staff, or visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations made on 08/26/24 during the tour of the facility with the Maintenance Director at 1:41 p.m., there was around 100 cardboard boxes of gloves, plastic wrapped Respiratory items, and cardboard wrapped Respiratory items stored within five feet of stationary liquid oxygen containers in the oxygen	K 0923	K- 923 Gas Equipment- Cylinder and Container Storage The Corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents. other residents that have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The 100 carboard boxes of gloves, plastic wrapped Respiratory items, and cardboard wrapped Respiratory items stored in the Oxygen Storage and Transfilling room were removed on 8/26/24 by the Maintenance Director. What measures will be put into	09/10/2024

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	storage and transfilling room. Based on interview at the time of observation, the Maintenance Director acknowledged the combustible materials were stored within five feet of stationary liquid oxygen containers adding that he would address this issue as soon as possible. This finding was reviewed with the Administrator 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: The Maintenance Director was educated on K-923 by the Executive Director on 9/5/24 to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment is maintained. How the corrective action will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: The Maintenance Director and/or will the oxygen storage areas to insure they are conducted in accordance with K- 923, 1x weekly x3 months, then 1x monthly for 3 months. Any negative findings will be immediately remedied. All findings will be brought to the facility Quality Assurance Committee meeting for monitoring.	