STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING -- B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/25/23 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Emergency Preparedness survey, Majestic Care of New Haven was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 120 and had a census of 88 at the time of this survey. Quality Review completed on 05/30/23	E 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.	
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: 05/25/23 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Life Safety Code survey, Majestic Care of New Haven was found not in compliance with Requirements for Participation in	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carmela Tuttle	HFA	06/12/2023

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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	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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility is partially protected by a Type II EES 60KW diesel powered generator. The facility has a capacity of 120 and had a census of 88 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered which the exception of a detached building housing the emergency generator and used for storage of maintenance equipment. Quality Review completed on 05/30/23			
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge ramp and steps with handrails was readily accessible and safe to use at all times. LSC Section 7.2.5.4.1 Guards complying with 7.2.2.4 shall be provided for ramps, 7.2.5.4.2 Handrails complying with	K 0227	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility obtaining bids for railing	06/12/2023

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	7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 in. (150 mm). This deficient practice could affect 25 residents evacuated from the front exit. Findings include: Based on an observation with the Maintenance Director on 05/25/23 at 12:00 p.m., the handrails for the exit ramp and the two steps from main entrance was loose, broken from supports, and could be pushed back and forth. This condition made the handrails unsteady for someone using the handrails for support. Based on an interview at the time of observation, the Maintenance Director stated the railing was loose and needed repaired. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		repair/replacement. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other residents identified as being affected What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does nto recur: Maintenance Director educated on preventative maintenance on exit ramp safety How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit exit railings for safety weekly for 2 months then monthly for 4 months. Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance. Percentage of compliance may determine modifications to frequency of audits based on recommendations.	

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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 #1.) Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 2 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	K 0353	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Full hydrostatic flush start date 6.6.2023 and sprinkler head to be replaced by 6.16.2023. How other residents having 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	06/16/2023

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	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 records review with the Maintenance Director and the Administrator on 05/25/23 at 10:50 a.m., the Five-Year Internal Pipe Inspection dated 08/20/20 stated "System needs flushed." There was no information on the form to indicate why the system need flushed. Based on interview at the time of records review, the Maintenance Director and the Administrator both acknowledged the report stated to flush the sprinkler system, and stated a flush of the system is scheduled and the facility has started a fire watch until the flush is completed. #2.) Based on observation and interview, the facility failed to ensure 1 of 1 sprinklers in the 400-hall hot water heater room. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in one smoke compartment.		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance educated on reviewing contractor recommendations and sprinkler head cleanliness. How the corrective aciton will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Maintenance Director to audit contractor recommendations and sprinkler heads weekly for 2 months then monthly for 4 months. Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance. Percentage of compliance may determine modifications to frequency of audits based on recommendations.	

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	Findings include: Based on observation with the Maintenance Director and the Administrator on 05/25/23 at 12:55 p.m., the sprinkler in the 400-hall hot water heater room was green and showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler head showed signs of corrosion. The findings were reviewed with the Maintenance Director and the Administrator at the exit conference. 3-1.19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.	K 0712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Fire drills are being conducted quarterly and every shift within the quarter	06/05/2023

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	Findings include: Based on records review with the Maintenance Director and the Administrator on 05/25/23 at 10:02 a.m., no documentation was available to show a third shift fire drill for the first quarter of 2023 was conducted. Based on interview at the time of record review, the Maintenance Director stated the aforementioned drill was conducted but could not find the documentation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents had the potential to being affected What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does nto recur: Maintenance Director educated on fire drill timeliness How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Executive Director/Designee will audit fire drill documentation monthly for 6 months. Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance. Percentage of compliance may determine modifications to frequency of audits based on recommendations.	
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 Based on observation and interview, the facility failed to ensure 1 of 1 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 up to 5 residents outside of the Case Managers office. Findings include: Based on observations with the Maintenance Director on 05/25/23 at 12:25 p.m., a refrigerator	K 0920	hat corrective action will be accomplished for those residents found to have been affected by the deficient practice: Power strip was removed from office on 5.20.2023 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	05/30/2023

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	(high power draw equipment) was plugged into and supplied power by a power strip in the Case Managers office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		Whole house audit completed with no other power strips identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does nto recur: Maintenance Director educated on appropriate electrical useage How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Maintenance Director/Designee will audit offices and resident rooms for power strips weekly for 1month then monthly for 5 months. Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance. Percentage of compliance may determine modifications to frequency of audits based on recommendations.	