STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155243	A. BUILDING -- B. WING	08/04/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/04/22 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 At this Emergency Preparedness survey, Majestic Care of Lafayette was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 122 certified beds. At the time of the survey, the census was 94. Quality Review completed on 08/09/22	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 8-26-22 to the life safety survey completed on 8-4-2022. We respectfully request a paper review and will provide any additional information requested.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	155243	A. BUILDING -- B. WING	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	It is the practice of this facility to review and update the Emergency	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING -- B. WING	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(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
	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. The most recent update which could be found dated 01/01/2019. Based on an interview during records review, the Executive Director stated the EEP was reviewed recently but during the survey no documentation was provided indicating the EPP was updated within the last year. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m.		Preparedness Plan at least annually. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Emergency Preparedness Plan has been reviewed and updated by the QA committee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ED and maintenance director were reeducated on the deficient practice. The ED and QA committee reviewed and updated the Emergency Preparedness plan as needed and signed completion. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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			An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency preparedness plan is updated with any additional changes or corrections. This review will be documented with a signature sheet and the attendees which must include the Executive Director and Director of Maintenance.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. The most recent update which could be found dated 01/01/2019. Based on an interview during records review, the Executive Director stated the Policies and Procedures were reviewed recently but during the survey no documentation was provided indicating the Policies and Procedures were updated within the last year. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m.	E 0013	It is the practice of this facility to review and update the Emergency Preparedness Plans Policies and procedures at least annually. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Emergency Preparedness Plan has been reviewed and updated by the QA committee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ED and maintenance director were reeducated on the deficient practice. The ED and QA committee reviewed and updated	08/18/2022

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			the Emergency Preparedness policy and procedures as needed and signed completion. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency preparedness plan policy and procedures are updated with any additional changes or corrections. This review will be documented with a signature sheet and the attendees which must include the Executive Director and Director of Maintenance.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication			

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. The most recent update which could be found dated 01/01/2019. Based on an interview during records review, the Executive Director stated the Communication Plan was reviewed recently but during the survey no documentation was provided indicating the Communication Plan was updated within the last year. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m.	E 0029	It is the practice of this facility to review and update the Emergency Preparedness Plans Communication plan at least annually. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Emergency Preparedness Communication Plan has been reviewed and updated by the QA committee. A cover letter was added with date and signatures. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ED and maintenance director were reeducated on the deficient practice. The ED and QA committee reviewed and updated the Emergency Preparedness	08/18/2022

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			plans Communication plan, added a cover sheet with date that it was updated and reviewed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency preparedness plan is completed in its entirety. Any additional changes or corrections will be addressed with updated date. This review will be documented with a signature sheet and the attendees which must include the Executive Director and Director of Maintenance.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54,			

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	Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this			

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	section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. The most recent update which could be found dated 01/01/2019. Based on an interview during records review, the Executive Director stated the Training and Testing Plan was reviewed recently but during the survey no documentation was provided indicating the Training and Testing Plan was updated within the	E 0036	It is the practice of this facility to review and update the emergency preparedness plans training and testing plan at least annually. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Emergency Preparedness Plans training and testing plan has been reviewed	08/18/2022

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	last year. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m.		and updated by the QA committee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ED and maintenance director were reeducated on the deficient practice. The ED and QA committee reviewed and updated the Emergency Preparedness plans training and testing plan as needed and signed completion. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency preparedness plans training and testing plan is updated with any additional changes or corrections. This review will be documented with a signature sheet and the attendees which must include the Executive Director and Director of Maintenance.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2),			

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	485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or			

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	155243	A. BUILDING -- B. WING	08/04/2022

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

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	(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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	led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise			

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	the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.			

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	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):]			

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	(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least			

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	twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically			

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	relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual,	E 0039	It is the practice of this facility to test emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no	08/26/2022

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	facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the facility was able to provide documentation of its response to the COVID-19 Public Health Emergency, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Executive Director agreed that a second exercise of choice was not conducted.		identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. A table top exercise was completed on 8-10-22. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ED and maintenance director were reeducated on the deficient practice. A table top exercise was completed on 8-10-22 with documentation and signatures of attendees received. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency preparedness plan has conducted exercises to test the emergency plan. Documentation of these drills/exercises will be reviewed by	

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	This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m.		the quality assurance committee.	
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: 08/04/22 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 At this Life Safety Code survey, Majestic Care of Lafayette was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 94 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 8-26-22 to the life safety survey completed on 8-4-2022. We respectfully request a paper review and will provide any additional information requested.	

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	facility services were sprinklered except for three detached storage garages which were used for storage and to store maintenance equipment, that were not sprinklered. Quality Review completed on 08/09/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of over 10 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the following was noted: a) the exit door by resident room 109 was blocked and obstructed with a Hoyer lift sitting in front of the exit door. b) The exit door on B-3 was blocked and obstructed with a wheelchair parked in front of the exit door. The Director of Maintenance stated that dialysis sometimes leaves the wheelchairs in front	K 0211	It is the practice of this facility to ensure that the means of egress are continuously maintained free of all obstructions. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The hoyer lift was removed and wheelchair was moved from being in front of the exit doors	08/18/2022

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	of that door. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The equipment was removed from the means of egress. All other doors were audited and no issues found. All staff were inserviced regarding this deficient practice. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will audit the entire facility daily for 30 days. weekly x 4 weeks and then monthly thereafter. Findings will be remedied immediately and administrator notified. All findings and discovery will be discussed at the quarterly QA meetings. Administrator to monitor	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the			

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(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
	clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS			

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	155243	A. BUILDING 01 B. WING	08/04/2022

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

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	Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect 25 occupants in the facility. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., 1 of 2 main dining room exit doors would not open when easily on the first try when tested. The Surveyor, then the Director of Maintenance tried to open the door, and the Director of Maintenance was able, after considerable effort to open the exit door. The Director of Maintenance stated he was aware of the issue and had an appointment with the facility contractor to work on several doors throughout the facility. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m.	K 0222	It is the practice of this facility to ensure all the exterior exit doors were readily accessible and able to open on first try **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The main dining room door has been maintained to open freely and easily without excessive pressure. The main door in dining room code has been posted and 15 second relay is operational. **What measures will be put into**	08/19/2022

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

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	2. Based on observation and interview, the facility failed to ensure the means of egress through the Main dining exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 25, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the Main Dining exit door (1 of 2), marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit nor was there 15 second delayed egress signage on the door. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice does not recur:** The main dining room door has been maintained to open freely and easily without excessive pressure. The main door in dining room code has been posted and 15 second relay is operational. All other exterior exits have been assessed and meet regulation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will audit the entire facility to ensure that all doors are readily accessible and able to open on first try. Maintenance or designee will audit doors 2x weekly for 4 weeks and then 1 x weekly for 6 months and thereafter. Any negative findings will be immediately remedied and ED informed. All findings will be brought to the QA meeting. Administrator to monitor.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in			

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	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 over 15 exit signs were continuously illuminated. This deficient practice could affect 6 staff in the boiler room. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the Exit light in the Mechanical /Boiler Room above the exit door was not illuminated. Based on an interview with the Director of Maintenance at the time of observation, it was unclear why the exit sign was not illuminated. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1.19(b)	K 0293	It is the responsibility of this facility to ensure that all exit signs are continuously illuminated. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The exit sign above mechanical/boiler room light bulb was replaced. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The exit sign above mechanical/boiler room light bulb was replaced. All other exit lights were audited and all were fully functioning. **How the corrective action will be monitored to ensure the deficient practice**	08/18/2022

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			will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or his designee will will audit doors 1x weekly x3 months and then 1 x monthly for 3 months Any negative findings will be immediately remedied and ED informed. All findings will be brought to the QA meeting. Administrator to monitor.	
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. 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 observation and interview, the facility	K 0324	It is the responsibility of this	08/19/2022

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	failed to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice was not in a resident area but could affect 6 kitchen staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the kitchen range hood extinguishing system nozzles (4 of 4 over 2 different appliances) were not properly positioned over the cooking equipment under the hood. All nozzles were pointed straight down but the cooking equipment orientation did not align with the direction of the nozzles. The Director of Maintenance agreed that the nozzle direction did not match the appliance locations. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		facility to ensure that the range hood extinguishing system is maintained and in proper working condition. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The nozzles were realigned with the cooking equipment and are correctly positioned. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The nozzles of the range hood extinguishing system were realigned with the cooking equipment and are correctly positioned. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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			The maintenance director and/or his designee will will audit range hood system 1x weekly x3 months and then 1 x monthly for 3 months Any negative findings will be immediately remedied and ED informed. All findings will be brought to the QA meeting. Administrator to monitor.	
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 a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method	K 0346	It is the responsibility of this facility to ensure a 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 24 hour period. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice**	08/19/2022

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	or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Director of Maintenance acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m. 3.1-19(b)		**will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The fire plan was updated to include to notify the ISDH via gateway if there is a disruption in the fire alarm system and it is out of service for four hours in a 24 hour period. If the gateway portal isn't operational an incident reporting form must be emailed or faxed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The fire plan was updated to include to notify the ISDH via gateway if there is a disruption in the fire alarm system and it is out of service for four hours in a 24 hour period. If the gateway portal isn't operational an incident reporting form must be emailed or faxed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The executive director and/or his designee will review the fire disaster plan at least monthly to update any changes that need to be made. The disaster plan will be reviewed quarterly in the QA	

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			meetings and signed by attendees. Administrator to monitor.	
K 0353 SS=E 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 observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 6 residents and 3 staff. Findings include: Based on observations and interview during a	K 0353	It is the practice of this facility to maintain the ceiling construction throughout the facility **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be**	08/19/2022

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	tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., in the Linen Closet on Cedar Hall there was a 3 inch gap around the sprinkler head. This condition could delay the activation of the sprinklers. Based on interview at the time of observation, the Director of Maintenance agreed there was an unsealed gap in the ceiling around the sprinkler head. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		**taken.** All residents have the potential to be affected but none were identified. The gap around the sprinkler head in the linen closet was repaired. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The gap around the sprinkler head was repaired and maintained. A full facility tour was completed and there were no other findings of obstructions from the sprinkler heads. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will audit the entire facility to ensure that the ceiling is in full repair and there are no obstructions and gaps. Audit will be conducted monthly x6 months and quarterly thereafter. All findings will be immediately remedied and brought to the attention of the ED. Findings will be discussed at the quarterly QA meetings.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service			

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	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 facility. Findings include:	K 0354	It is the responsibility of this facility to ensure a written policy for the protection of residents indicating procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 10 hours or more in a 24 hour period. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The fire plan was updated to include to notify the ISDH via gateway if there is a	08/18/2022

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	Based on records review and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Director of Maintenance acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m. 3.1-19(b)		disruption in the sprinkler system and it is out of service for ten hours in a 24 hour period. If the gateway portal isn't operational an incident reporting form must be emailed or faxed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The fire plan was updated to include to notify the ISDH via gateway if there is a disruption in the sprinkler system and it is out of service for ten hours in a 24 hour period. If the gateway portal isn't operational an incident reporting form must be emailed or faxed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The executive director and/or his designee will review the fire disaster plan at least monthly to update any changes that need to be made. The disaster plan will be reviewed quarterly in the QA meetings and signed by attendees. Administrator to monitor.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 01 B. WING	08/04/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The double doors near the kitchen, equipped with latching hardware. b) The double doors to the Lounge on Cedar Hall, equipped with a door coordinator. c) The Linen Room on Cedar Hall near resident room 231. d) The Clean Laundry corridor door, equipped with a self-closing device. e) The Linen Closet near resident room 108, equipped with a self-closing device. f) The double doors to the Lounge on B-1, equipped with a door coordinator. g) The Dirty Utility corridor door on B-3, the latch had paper and plastic bags stuffed into the jamb to prevent the door from latching. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 12 residents.	K 0363	It is the practice of this facility to ensure all corridor doors have no impediment to closing and latching into the door frame. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The following listed doors have been adjusted, or maintained and properly latch into the door frame. The double doors near the kitchen, equipped with latching hardware. The double doors to the Lounge on Cedar Hall, equipped with a door coordinator. The Linen Room on Cedar Hall near resident room 231. The Clean Laundry corridor door, equipped with a self-closing device. The Linen Closet near resident room 108, equipped with a self-closing device. The double doors to the Lounge on B-1, equipped with a door coordinator.	08/25/2022

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	Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the following corridor doors had holes which penetrated completely through the door: A) The Dirty Utility on Cedar Hall had a 2 inch hole in the corridor door. B) The Pantry Storage door in the Kitchen had a hole as a result of the door knob being broken, additionally the door was propped open. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		The Dirty Utility corridor door on B-3, the latch had paper and plastic bags stuffed into the jamb to prevent the door from latching. The following two doors have been replaced or corrected to prevent the passage of smoke. The Dirty Utility on Cedar Hall had a 2 inch hole in the corridor door. The Pantry Storage door in the Kitchen had a hole as a result of the door knob being broken, additionally the door was propped open. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A full audit of the facility found that no other doors were deficient of this practice. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will audit the entire facility to ensure that all fire doors are properly latching and meet federal regulations. Corridor audits will be completed weekly x 4 weeks then monthly times 3	

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			months then quarterly times 2 quarters. All findings will be immediately remedied and brought to the QA meeting. Administrator to monitor findings	
K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 1. Based on observation and interview, the facility failed to ensure 3 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 25 residents. Findings include: Based on observations and interview during a tour of the facility with the Director of	K 0374	It is the responsibility to ensure the smoke barrier doors will restrict the movement of smoke for at least 20 minutes. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice**	08/18/2022

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	Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the following smoke doors failed to close properly: a) The double doors leading from the service hall into the main corridor did not self-close and latch. b) The double doors near the main lobby leading into the corridor did not self-close and latch. c) The double doors near the beauty shop did not self-close and latch. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 20 residents in two smoke compartments Finding include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the smoke barrier doors entering the Ambulance Entrance had a 1/2 inch gap between the doors when closed. The felt astragal on one side was missing. Based on an interview at the		**will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The double doors leading from the service hall into the main corridor self-closes and latches correctly. The double doors near the main lobby leading into the corridor self-close and latch correctly. The double doors near the beauty shop self-close and latch. The felt astragal was replaced on the door by ambulance entrance and 1/2 inch gap was corrected. The attic hatch door was closed and secured. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The double doors leading from the service hall into the main corridor self-closes and latches correctly. The double doors near the main lobby leading into the corridor self-close and latch correctly. The double doors near the beauty shop self-close and latch. The felt astragal was replaced on the door by ambulance entrance and 1/2 inch gap was corrected. The attic hatch door was closed and secured. All other doors were audited and met federal guidelines. **How the corrective action will**	

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	time of observation, the Director of Maintenance agreed there was a gap larger than 1/8 inch between the smoke doors when closed due to the astragal being missing on one side. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3. Based on observation and interview, the facility failed to ensure 1 of over 6 ceiling smoke barrier attic hatch doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice affects all residents. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the smoke barrier attic hatch near the maintenance was propped open. Based on interview during the time of observations, the Director of Maintenance acknowledged the attic hatch smoke barrier door was not closed and stated to his knowledge no one was working in the attic. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m.		**be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will audit the entire facility to ensure that all smoke barrier doors restrict the movement of smoke for at least 20 minutes. Maintenance or designee will audit doors 2x weekly for 4 weeks and then 1 x weekly for 6 months and thereafter. Any negative findings will be immediately remedied and ED informed. All findings will be brought to the QA meeting. Administrator to monitor.	

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	3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment	K 0511	It is the responsibility of this facility to ensure wet locations are provided with ground fault circuit interrupter protection. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The ice machine is now plugged into a GFCI outlet. The electrical box in kitchen with exposed wires was maintained and cover was replaced. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	08/12/2022

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	shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents while at the ice machine. Findings include:		**practice does not recur:** The ice machine is now plugged into a GFCI outlet. The electrical box in kitchen with exposed wires was maintained and cover was replaced. All other wet areas were audited and all met requirements of this regulation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will review all wet areas weekly x3 months and monthly x3 months to assure all wet areas are secure. Any negative findings will be immediately remedied and brought to the administrator. Findings will be brought to the quarterly QA meetings and signed by attendees. Administrator to monitor.	

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	Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., the ice machine in the soda machine area was connected to an electric receptacle which was being used to power the freestanding ice machine, with it's own water supply. The ice machine was located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). The Director of Maintenance at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 2. Based on observation, the facility failed to ensure 1 of 1 electrical boxes in the kitchen were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 6 staff in the kitchen area. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., an electrical box in the kitchen, on a wall			

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	next to a fan, had exposed wires and was missing a cover. The Director of Maintenance stated the previous Director of Maintenance had started the fan project but didn't complete it and that is why the wires were exposed in the box, in the kitchen dishwashing area where the floor was regularly wet. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)			
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to maintain all dampers in the Social Services office in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years	K 0521	It is the responsibility of this facility to maintain all dampers **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none	08/12/2022

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	except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect 3 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., in the Social Services office the ceiling HVAC vent was missing a cover. Insulation had been stuffed into the vent which contained a HVAC Damper. Records Review revealed that smoke damper inspections were last completed on 01/11/21 by the facilities contractor. The Director of Maintenance stated that perhaps someone in the Social Services office was either to hot or cold and was attempting to manage the airflow. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		were identified. The insulation was removed from damper in social service office. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The insulation was removed from the damper in the social service office. All other dampers were inspected and met regulation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will review all dampers weekly x3 months and monthly x3 months to assure all dampers are properly maintained. Any negative findings will be immediately remedied and brought to the administrator. Findings will be brought to the quarterly QA meetings and signed by attendees. Administrator to monitor.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	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 quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review of the "Logbook Documentation regarding Fire Drills" and interview with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., 8 of 12 quarterly fire drills were conducted near the end of the month, near the 30th day of the month. These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m. 3.1-19(b)	K 0712	It is the responsibility of this facility to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective 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 was conducted on 8/9/22 at 5:00pm. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A fire drill was conducted at 5 pm on 8/9/2022. The maintenance director was inserviced on	08/12/2022

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			staggering dates and times throughout the month. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will conduct monthly fire drills that are on different shifts and staggered throughout the month, quarter and year. The times will also be staggered through a 24 hour period so they all dont' fall at the same time on the same shift. Drills will be brought to the quarterly QA meetings for review and signed by attendees. Administrator to monitor.	
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			

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	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 staff and 10 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., in the Near the Ambulance Entrance to the facility there were between 75 and 100 cigarette butts on the ground near the building, in the mulch, yard and in the trach can near the facility. The designated smoking area was an additional 50 feet from the location of the aforementioned cigarette butts. The Director of Maintenance stated that it was likely the result of staff not going to the designated smoking area, which is farther away from the building. This finding was acknowledged by the Director of	K 0741	It is the responsibility of this facility to ensure all smoking areas are maintained by disposing cigarette butts in a mental or noncombustible container with self-closing cover. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The cigarette butts have been cleaned and thrown in appropriate container. All staff have been inserviced on	08/19/2022

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	Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)		smoking areas and where to dispose of cigarette butts. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The cigarette butts have been cleaned and thrown in appropriate container. All staff have been inserviced on smoking areas and where to dispose of cigarette butts. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will walk grounds 3xweekly for 1 month, 2 x weekly for 1 month and weekly for 4 months and continue. Any negative findings will be immediately remedied and brought to the administrator. All staff will continue to be inserviced if negative findings occur. Findings will be brought to the quarterly QA meetings and signed by attendees. Administrator to monitor.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and			

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	Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires	K 0914	It is the practice of this facility to complete an electrical outlet receptacle testing program once every 12 months and sure documentation of all patient bed locations. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents **How other residents that have the potential to be affected by**	08/18/2022

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	the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on review of the tells report of inspections completed, documentation with the Director of Maintenance and the Executive Director on 08/04/22 between 10:15 a.m. and 1:00 p.m., an itemized listing of inspection and testing electrical outlet receptacles was not available for review. Based on interview at the time of record review, the Director of Maintenance stated electrical receptacle testing documentation simply stated that the previous Director of Maintenance had done the testing but an itemized list of rooms and receptacles was not available for the current year or anytime prior to January 2020 and the onset of the COVID-19 Pandemic. This finding was acknowledged by the Director of Maintenance and the Executive Director at the time of records review and again at the exit conference at 5:00 p.m. 3.1-19(b)		**the same defective practice will be identified and what corrective action will be taken.** Potentially all residents could be affected but none were identified. The maintenance director has completed an electrical outlet receptacle test was completed at all patient bed locations with documentation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director has completed an electrical outlet receptacle test at all patient bed locations. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will complete annual receptacle test at all patient beds. Results of negative test will be immediately communicated to administrator. Results then brought to QA committee meeting.Administrator to monitor findings	

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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 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 up to 15 residents. Findings include:	K 0920	It is the practice of this facility to ensure that power strips and extension cords are not used for a substitute for fixed wiring. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents	08/18/2022

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	Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., power strip were being used to power a high power draw equipment: A) In the Medical Records Office - a dorm style refrigerator. B) In Room 200 - a portable air conditioning unit. C) In the ADON Office - a dorm style refrigerator. D) In the Birchwood Managers Office - a dorm style refrigerator and coffee machine. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 2. Based on observation and interview, the facility failed to ensure flexible cords were 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 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and		**How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The following items were moved to not be plugged in with a power strips or power strips were removed. the Medical Records Office - a dorm style refrigerator. B) In Room 200 - a portable air conditioning unit. C) In the ADON Office - a dorm style refrigerator. D) In the Birchwood Managers Office - a dorm style refrigerator and coffee machine. The power strip in in the Clean Utility area on Cedar Hall a power strip was being used to power equipment has been secured. The work light that was being powered by an extension cord was removed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A full audit of the facility found that no other deficient practices were present. All staff were inserviced on power strips and extension cords. **How the corrective action will be monitored to**	

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	4:30 p.m., in the Clean Utility area on Cedar Hall a power strip was being used to power equipment and was not secured, dangling from the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Director of Maintenance agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was acknowledged by the Director of Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3. Based on observation and interview, the facility failed to ensure flexible cords were 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 up to 3 staff in the maintenance attic area. Findings include: Based on observations and interview during a tour of the facility with the Director of Maintenance on 08/04/22 between 1:00 p.m. and 4:30 p.m., in the maintenance of the attic, a work light was being powered by an extension cord. Other extension cords were laying on the ground near the work light. Based on interview at the time of observation, the Director of Maintenance acknowledged an extension cord was in use as described above and that he was unaware that it was an issue. This finding was acknowledged by the Director of		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will authorize usage of power strips and report to safety committee weekly for 4 weeks and monthly for 6 months and notify administrator of findings immediately. It will continued to be monitored and documented in TELS. Findings will be brought to quarterly QA meeting.	

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	Maintenance at the time of discovery and observation and again at the exit conference with the Executive Director and Director of Maintenance present at 5:00 p.m. 3.1-19(b)			