PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155243		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted '2022	
	PROVIDER OR SUPPLIER			300 WII	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRIATE	
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!		DATE
E 0004 SS=C Bldg	conducted by the In accordance with 42  Survey Date: 08/04  Facility Number: 0 Provider Number: 1002  At this Emergency I Care of Lafayette w compliance with En Requirements for M Participating Provid 483.73  The facility has 122 the survey, the cens  Quality Review con 403.748(a), 416.5441.184(a), 482.14484.102(a), 485.66485.727(a), 485.96491.12(a), 494.626	200147 155243 266900 Preparedness survey, Majestic as found in substantial nergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR  certified beds. At the time of us was 94.  npleted on 08/09/22 4(a), 418.113(a), 5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),	E 0	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequest that the plan of correct be considered our allegation of compliance effective 8-26-22 tife safety survey completed of 8-4-2022. We respectfully required a paper review and will provide additional information requested.	cility tion of to the n quest e any	
	Annually §403.748(a), §416 §441.184(a), §460 §483.73(a), §483. §485.68(a), §485. §485.920(a), §486 §494.62(a).	5.54(a), §418.113(a), 0.84(a), §482.15(a), 475(a), §484.102(a), 625(a), §485.727(a), 6.360(a), §491.12(a), comply with all applicable					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

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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	OF CORRECTION	IDENTIFICATION NUMBER  155243	A. BUILI B. WING			COMPL 08/04/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  300 WINDY HILL DR  LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CV MUST BE PRECEDED BY FULL PREFLY (EACH COR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	must develop esta comprehensive er program that mee section. The emer program must incl the following elem (a) Emergency Pla develop and main preparedness plar and updated at lea must do all of the * [For hospitals at §485.625(a):] Emergency Plan. develop and main preparedness required to the comprehensive er program that mee section, utilizing at * [For LTC Facilities Emergency Plan. develop and main preparedness plar and updated at lease * [For ESRD Facil Emergency Plan. develop and main	uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, ents:  an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable d local emergency uirements. The [hospital or inp and maintain a mergency preparedness ts the requirements of this in all-hazards approach.  es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually.  ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],					
		riew and interview, the facility Lupdate the Emergency	E 0004		t is the practice of this facility t review and update the Emerge		08/12/2022

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/04/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  300 WINDY HILL DR  LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5) DULD BE COMPLETION PROPRIATE DATE		
		EPP) at least annually in CFR 483.73(a). This deficient t all occupants.		Preparedness Plan at le annually.	east		
	Findings include:  Based on records redictor of Mainter Director on 08/04/2 p.m., the EEP lacked could be found to stand updated within update which could Based on an intervious Executive Director recently but during was provided indicated within the last year acknowledged by the and the Executive I	eview and interview with the nance and the Executive 2 between 10:15 a.m. and 1:00 and a cover page, and no date how the EPP was reviewed the last year. The most recent be found dated 01/01/2019. The word dated the EEP was reviewed the survey no documentation atting the EPP was updated		The corrective action to those residents found affected by the deficient practice includes: The identified residents  How other residents the the potential to be affected by the deficient practice action will be affected and we corrective action will be affected but none we identified. The Emergent Preparedness Plan has reviewed and updated be committee.  What measures will be place and what system changes will be made to ensure that the deficient practice does not recurreducated on the deficite practice. The ED and Committee reviewed and the Emergency Prepareducated on the deficite practice. The ED and Committee reviewed and the Emergency Prepareducated and signed completion.  How the corrective act be monitored to ensure the deficient practice we recur, i.e., what quality assurance program wi into place:	to be nt ere are no  nat have cted by ectice what be taken. otential to ere ncy been by the QA  put into nic to nt r: The ED or were ient QA d updated edness plan  ion will e vill not		

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			ON	MB NO. 0938-039
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION  ID PLAN OF CORRECTION IDENTIFICATION NUMBER  155243 A. BUILDING  B. WING		COMP	(X3) DATE SURVEY COMPLETED 08/04/2022		
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR 'ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		(X5) COMPLETION DATE
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.920(b), §486 §494.62(b).  (b) Policies and proper and imples preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies and proper and the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies and proper and the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies and proper and the emergency (b) Policies and proper and the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies and proper and the emergency (b) Policies and proper and the emergency (a) of this section, paragraph (b) occurrence (b) The emergency (c) occurrence	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),		An audit will be conducted quarterly with the quality assurance committee to as that the Emergency prepar plan is updated with any acchanges or corrections. The review will be documented signature sheet and the att which must include the Exel Director and Director of Maintenance.	redness dditional nis with a tendees	

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years.

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155243		A. BUILDING B. WING	onstruction 	COMPLETED 08/04/2022	
NAME O	F PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD INDY HILL DR	
MAJES	STIC CARE OF LAFA	YETTE	LAFA	/ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and procedures. I develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The policible reviewed and the section of the emergency (a) of this section, paragraph (a)(1) communication pl preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The policible address manager nonmedical emerging the procedures in the policies and previewed and updeduced the particular of the particular procedures. The policies and previewed and updeduced the particular procedures and procedures develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) of this section,	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.  The ments for PACE and procedures and procedures and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not puipment, power, or water end energencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years.  The dialysis facility must			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	A. BU	A. BUILDING COMI			SURVEY ETED (2022
	PROVIDER OR SUPPLIER		<u> </u>	300 WII	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING DIFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
1/40	section. The policible reviewed and upars. These ement limited to, fire, failures, care-relative supply interruption likely to occur in the area.  Based on record review and Preparedness Plan's at least annually in 483.73(a). This definition occupants.  Findings include:  Based on records represented by the EEP lacked could be found to shand updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within update which could based on an interview and updated within updated	sies and procedures must updated at least every 2 argencies include, but are equipment or power and emergencies, water in, and natural disasters in facility's geographic ariew and interview, the facility all update the Emergency (EPP) Policies and Procedures accordance with 42 CFR cient practice could affect all ariem and the Executive 2 between 10:15 a.m. and 1:00 d a cover page, and no date into the last year. The most recent be found dated 01/01/2019. The found dated 01/01/2019 are during records review, the stated the Policies and viewed recently but during the tation was provided indicating incedures were updated within anding was acknowledged by intenance and the Executive of records review and again at at 5:00 p.m.	E 00		It is the practice of this facility review and update the Emerge Preparedness Plans Policies a procedures at least annually.  The corrective action taken for those residents found to be affected by the deficient practice includes: There are identified residents  How other residents that have the potential to be affected by the deficient will be identified and what corrective action will be taken. All residents have the potential to be affected but not were identified. The Emergence Preparedness Plan has been reviewed and updated by the committee.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The and maintenance director were reeducated on the deficient practice. The ED and QA committee reviewed and update	ency and  or  no  re y  QA  tto	08/18/2022

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155243	B. W	ing		08/04/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  300 WINDY HILL DR  LAFAYETTE, IN 47905				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDEDIS DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0029 SS=C Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62( Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.4 §485.68(c), §485.6 §485.920(c), §486 §494.62(c).	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),			the Emergency Preparedness policy and procedures as need and signed completion.  How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be printo place:  An audit will be conducted quarterly with the quality assurance committee to assur that the Emergency preparedre plan policy and procedures are updated with any additional changes or corrections. This review will be documented with signature sheet and the attention which must include the Execution Director and Director of Maintenance.	ty ut  re ness e h a dees	

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an emergency preparedness communication

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155243		A. BUILDING  B. WING		onstruction 	COMPLETED 08/04/2022		
	PROVIDER OR SUPPLIER			300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	(X5) COMPLETION DATE
	plan that complies local laws and mu at least every 2 ye facilities]. Based on record rev to review and update Preparedness Plan's least annually in accupants.  Findings include:  Based on records reduction of Mainter Director of Mainter Director of Mainter Director on 08/04/2 p.m., the EEP lacked could be found to shand updated within update which could Based on an interviex executive Director was reviewed recent documentation was Communication Playear. This finding we Director of Mainter	swith Federal, State and st be reviewed and updated ears [annually for LTC view and interview, the failed the the Emergency (EPP) Communication Plan at cordance with 42 CFR dicient practice could affect all view and interview with the nance and the Executive 2 between 10:15 a.m. and 1:00 do a cover page, and no date though the last year. The most recent be found dated 01/01/2019. The most recent be found dated 01/01/2019. The stated the Communication Plan thy but during the survey no provided indicating the unwas updated within the last was acknowledged by the nance and the Executive of records review and again at	EO	TAG	It is the practice of this facility review and update the Emergence 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 identified residents  How other residents that have the potential to be affected by the deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected but no were identified. The Emergence Preparedness Communication Plan has been reviewed and updated by the QA committee cover letter was added with datand signatures.  What measures will be put in place and what systemic	to ency	
					changes will be made to ensure that the deficient practice does not recur: The and maintenance director wer reeducated on the deficient practice. The ED and QA committee reviewed and upda the Emergency Preparedness	e ited	

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DEPARTMENT CENTERS FOR		FORM APPROVED OMB NO. 0938-039				
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIE		300 W	TADDRESS, CITY, STATE, ZIP COD VINDY HILL DR YETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
				plans Communication plan, ac a cover sheet with date that it updated and reviewed.	was	
				How the corrective action wi be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place:	ity	
				An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency prepared plan is completed in its entiret Any additional changes or corrections will be addressed updated date. This review will documented with a signature sheet and the attendees which must include the Executive Director and Director of Maintenance.	ness y. with I be	
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and §403.748(d), §41 §441.184(d), §46	5(d), 483.475(d), 483.73(d), 625(d), 485.68(d), 620(d), 486.360(d), 62(d)				

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§494.62(d).

§485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d),

\*[For RNCHIs at §403.748, ASCs at §416.54,

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	ENT OF DEFICIENCIES  N OF CORRECTION	IDENTIFICATION NUMBER  155243	 JILDING	NSTRUCTION	COMPL 08/04/	ETED
	F PROVIDER OR SUPPLIER		300 WIN	ODRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testin develop and main preparedness train that is based on the in paragraph (a) of assessment at passection, policies at (b) of this section, plan at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The land maintain an estraining and testing the emergency plan of this section, risl (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plan section, risk at (a)(1) of this section at paragraph (b) of this section, risk at (a)(1) of this section at paragraph (b) of this section at paragraph (c) of this section a	Hospitals at §441.184, Hospitals at §482.15, C, CORFs at §485.68, G, "Organizations" under at §485.920, OPOs at IC/FHQs at §491.12:] (d) ng. The [facility] must tain an emergency ning and testing program ne emergency plan set forth of this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years.  Seat §483.73(d):] (d) Training LTC facility must develop mergency preparedness g program that is based on an set forth in paragraph (a) or assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least  4483.475(d):] Training and D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the et forth in paragraph (c) of this on, policies and procedures of this section, and the ean at paragraph (c) of this				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE ST A. BUILDING COMPLE				
		155243	B. WI	NG		08/04/	2022
	PROVIDER OR SUPPLIER		•	300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	section. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i).  *[For ESRD Facility Training, testing, a dialysis facility must emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation programupdated at every 2 Based on record reviewed and Preparedness Plan's Plan at least annual 483.73(a). This definition occupants.  Findings include:  Based on records repaired on 18.75 plan at least annual 483.73(a). This definition occupants.  Findings include:  Based on records repaired occupants.  Findings include:  Based on records repaired occupants.	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based aplan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and	E 00	)36	It is the practice of this facility review and update the emerge preparedness plans training at testing plan at least annually.  The corrective action taken for those residents found to be affected by the deficient practice includes: There are identified residents  How other residents that have the potential to be affected by the deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected but not were identified. The Emergence Preparedness Plans training a testing plan has been reviewer.	ency nd or no re y	08/18/2022

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	OF CORRECTION	IDENTIFICATION NUMBER  155243	A. BUILDING B. WING	onstruction 	COMPLETED 08/04/2022
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR 'ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION
	Director of Mainten Director at the time	ng was acknowledged by the ance and the Executive of records review and again at		and updated by the QA committee.	
	the exit conference	_		What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur: The and maintenance director we reeducated on the deficient practice. The ED and QA committee reviewed and upon the Emergency Preparednes plans training and testing planeded and signed completion.  How the corrective action we be monitored to ensure the deficient practice will not recur, i.e., what quassurance program will be into place:  An audit will be conducted quarterly with the quality assurance committee to asset that the Emergency prepare plans training and testing planed updated with any additional changes or corrections. This review will be documented we signature sheet and the atteem which must include the Executive Director and Director of Maintenance.	dated ess an as ion.  will ce ality put  ure dness an is s vith a ndees
E 0039 SS=C Bldg	441.184(d)(2), 482	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2),			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155243	B. W	ING		08/04	/2022
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		.727(d)(2), 485.920(d)(2),					
	` ' ' '	1.12(d)(2), 494.62(d)(2)					
	EP Testing Requi	. , . ,					
	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),						
		484.102(d)(2), §485.68(d)(2),					
		485.727(d)(2), §485.920(d)					
	(2), §491.12(d)(2)	, §494.62(d)(2).					
	*[For ASCs at §41	6.54, CORFs at §485.68,					
	OPO, "Organization	ons" under §485.727,					
	CMHCs at §485.9	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
		acility] must conduct					
		he emergency plan					
	1	ility] must do all of the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based						
	(A) When a comn	nunity-based exercise is					
	not accessible, co	nduct a facility-based					
	functional exercise	e every 2 years; or					
	(B) If the [faci	ility] experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the [facility]					
	is exempt from en	gaging in its next required					
	community-based	or individual, facility-based					
	functional exercise	e following the onset of the					
	actual event.						
	1 ' '	ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
	1 ''	s conducted, that may					
		limited to the following:					
	1 ' '	scale exercise that is					
	1	or individual, facility-based	1				1
	functional exercise	e; or					1

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(B) A mock disaster drill; or

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155243	B. W	ING		08/04/	2022
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
MAJESTI	MAJESTIC CARE OF LAFAYETTE			LAFAYE	ETTE, IN 47905		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION DD EFLY (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	, ,	ercise or workshop that is					
	•	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						
	· , , -	ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	the flacility of eme	rgency plan, as needed.					
	*[For Hospices at	418.113(d):]					
	(2) Testing for hospices that provide care in						
	the patient's home	e. The hospice must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The hospice must do					
	the following:						
	(i) Participate in a	a full-scale exercise that is					
	community based	every 2 years; or					
	(A) When a comm	nunity based exercise is not					
	accessible, condu	ct an individual facility					
	based functional e	exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	-	ency that requires activation					
		plan, the hospital is					
	exempt from enga	aging in its next required full					
	scale community-l	based exercise or individual					
	facility-based func	tional exercise following the					
	onset of the emer	<del>-</del>					
	` '	dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted, that may					
		limited to the following:					
	` '	scale exercise that is					
	community-based	-					
	functional exercise						
	(B) A mock disast	ter drill; or					
	(C) A tableton exe	ercise or workshop that is					l

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	OF CORRECTION	IDENTIFICATION NUMBER  155243	A. BUILDIN B. WING	NG <u></u>		COMPLE 08/04/2	TED
	PROVIDER OR SUPPLIER		30	REET ADDRESS, CITY, STA O WINDY HILL DR FAYETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCE)	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	(X5) COMPLETION DATE
TAG	led by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an eriod care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a community-(A) When a community-based functional exercise emergency exempt from engated full-scale community functional exercise emergency event. (ii) Conduct an activate may include, following:  (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise facilitator that including a narrated, cemergency scenarior.	and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan.  Epices that provide inpatient hospice must conduct me emergency plan twice spice must do the following: n annual full-scale exercise abased; or unity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the ditional annual exercise out is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion	TAG		FICIENCY		DATE
	maintain documer	d to challenge an ospice's response to and station of all drills, tabletop					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION	(X3) DATE COMPL 08/04/	ETED
	PROVIDER OR SUPPLIER		] ;	300 WIN	DDRESS, CITY, STATE, ZIP COD IDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the hospice's eme	ergency plan, as needed.					
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu- facility-based func (B) If the [PRTF, I an actual natural that requires activ plan, the [facility] its next required fr or individual, facili following the onse (ii) Conduct exercise or and th limited to the follo (A) A second full- community-based facility-based func (B) A mo (C) A tabletor is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or pre- to challenge an er (iii) Analyze t and maintain docu tabletop exercises	PRTF, Hospital, CAH] must is to test the emergency ar. The [PRTF, Hospital, efollowing: an annual full-scale exercise is an annual full-scale exercise is not act an annual individual, etional exercise; or Hospital, CAH] experiences or man-made emergency action of the emergency is exempt from engaging in a cull-scale community based ity-based functional exercise at of the emergency event. In an [additional] annual mat may include, but is not awing:  -scale exercise that is a for individual, a cultional exercise; or bock disaster drill; or prevention exercise or workshop that tor and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPL					
		155243	B. W	NG		08/04/	/2022
	PROVIDER OR SUPPLIER			300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	NOVIDENCEN AN OF CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	conduct exercises plan at least annual organization must (i) Participate in a that is community-(A) When a community-based functional exercise of the emergency (ii) Conduct a 2 years opposite to functional exercise of this section is cobut is not limited to (A) A second full-community-based based functional exercise of the exemption of the emergency (ii) Conduct a 2 years opposite to functional exercise of this section is cobut is not limited to (A) A second full-community-based based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an ereciii) Analyze the Pmaintain documer exercises, and emergency in the community of the problem star messages, or prepto challenge an ereciiii) Analyze the Pmaintain documer exercises, and emergency in the community of the problem star messages, or prepto challenge an ereciiii) Analyze the Pmaintain documer exercises, and emergency in the problem star messages, and emergency in the problem star messages.	ACE organization must to test the emergency ally. The PACE do the following: an annual full-scale exercise abased; or aunity-based exercise is not ct an annual individual, ational exercise; or aperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required aity based or individual, ational exercise following the gency event.  In additional exercise every the year the full-scale or a under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group an anarrated, emergency scenario, and a tements, directed coared questions designed mergency plan.  PACE's response to and anattion of all drills, tabletop mergency events and revise gency plan, as needed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURV	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED		
155243 B. WING 08/04/2022	2	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER  300 WINDY HILL DR		
MAJESTIC CARE OF LAFAYETTE LAFAYETTE, IN 47905		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	MPLETION	
<del> </del>	DATE	
(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		

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exercises to test the emergency plan at least

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING	<del></del>	COMPL	
		155243	B. W	ING		08/04/	/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAYE	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		e ICF/IID must do the					
	following:	n annual full acala avaraisa					
		n annual full-scale exercise					
	that is community						
	(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						
	` '	ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required					
	•	nity-based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		ditional annual exercise					
	, ,	but is not limited to the					
	following:						
	(A) A second full-s	scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	(B) A mock disast	er drill; or					
	(C) A tabletop exe	ercise 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 sta	tements, directed					
		pared questions designed					
	to challenge an er	• • •					
		CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's emer	rgency plan, as needed.					
	   *[For HHAs at §48	34.102]					
		e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:	<del>.</del>					
	_	full-scale exercise that is					
	community-based						

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	ENT OF DEFICIENCIES  N OF CORRECTION	IDENTIFICATION NUMBER  155243	lì í	UILDING	INSTRUCTION	COMPI 08/04	LETED
	F PROVIDER OR SUPPLIEF			300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	is not accessible, individual, facility-every 2 years; or.  (B) If the HH natural or man-material activation of the exempt from engaterial full-scale community facility based functionset of the emerical consection of the emerical consection of the emerical consection of the section is considered in the section of this section is considered in the section of this section is considered in the section of the the secti	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a ctements, directed pared questions designed mergency plan. HA's response to and chation of all drills, tabletop mergency events, and revise ency plan, as needed.  36.360] e OPO must conduct the emergency plan. The					

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER  155243	A. BUILDING B. WING		COMPLETED 08/04/2022
	F PROVIDER OR SUPPLIEF		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	problem statement prepared question emergency plan. It actual natural or no requires activation OPO is exempt for required testing exported for the emergency (ii) Analyze the Olymaintain document exercises, and enthe [RNHCl's and needed.  *[RNCHIs at §403 (d)(2) Testing. The exercises to test to the total comparent of the emergency of the emergency of the exercises to test to the exercises of the exercises, and enthe exercises. The Exercise of the exercises of the exercises of the exercises of the exercises of the exercises. The Exercise of the exercises of the exercises of the exercises of the exercises of the exercises. The Exercise of the exercises o	PO's response to and nation of all tabletop hergency events, and revise OPO's] emergency plan, as a.748]:  Part RNHCI must conduct the emergency plan. The her following:  Per-based, tabletop exercise as a led by a facilitator, using a per-relevant emergency plan. The her following and presence are all tabletop exercise is a led by a facilitator, using a per-relevant emergency plan. The her following and presence and her following and presence and her following and interview, and revise regency plan, as needed. The presency plan is needed. The facility derecises to test the emergency per year, including drills using the emergency inc	E 0039	It is the practice of this facility test emergency plan at least to per year, including unannound staff drills using the emergency procedures.  The corrective action taken for those residents found to be affected by the deficient practice includes: There are	wice ced y

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155243	B. W			08/04/		
		1						
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
					NDY HILL DR			
MAJEST	IC CARE OF LAFA	YETTE		LAFAYI	ETTE, IN 47905			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	facility-based funct	ional exercise.			identified residents			
	b. If the LTC facilit	ty experiences an actual natural						
	or man-made emerg	gency that requires activation			How other residents that ha	ve		
	of the emergency p	lan, the LTC facility is exempt			the potential to be affected I	ру		
	from engaging its next required full-scale in a				the same defective practice			
	community-based of	or individual, facility-based			will be identified and what			
	full-scale functiona	l exercise for 1 year following			corrective action will be			
	the onset of the actual event.				taken. All residents have the			
	(ii) Conduct an additional exercise that may				potential to be affected but no	ne		
	include, but is not l	imited to the following:			were identified. A table top			
	a. A second full-sca	ale exercise that is			exercise was completed on			
	community-based of	or an individual, facility-based			8-10-22.			
	functional exercise.							
	b. A mock disaster	drill; or			What measures will be put in	nto		
	c. A tabletop exerci	ise or workshop that is led by a			place and what systemic			
	facilitator that inclu	ides a group discussion, using			changes will be made to			
	a narrated, clinicall	y-relevant emergency scenario,			ensure that the deficient			
	and a set of probler	n statements, directed			practice does not recur: The	ED		
	messages, or prepar	red questions designed to			and maintenance director we	re		
	challenge an emerg	ency plan.			reeducated on the deficient			
	(iii) Analyze the L7	ΓC facility's response to and			practice. A table top exercise	;		
	maintain document	ation of all drills, tabletop			was completed on 8-10-22 wi	th		
	exercises, and emer	rgency events, and revise the			documentation and signature	s of		
	LTC facility's emer	gency plan, as needed in			attendees received.			
	accordance with 42	CFR 483.73(d)(2). This						
	deficient practice co	ould affect all occupants.			How the corrective action w	ill		
					be monitored to			
	Findings include:				ensure the deficient practice	•		
					will not recur, i.e., what qual	ity		
	Based on records re	eview and interview with the			assurance program will be p	out		
	Director of Mainter	nance and the Executive			into place:			
	Director on 08/04/2	22 between 10:15 a.m. and 1:00						
	p.m., the facility wa				An audit will be conducted			
	documentation of it	ts response to the COVID-19			quarterly with the quality			
	Public Health Emer	rgency, however, was unable to			assurance committee to assu	re		
	provide documenta	tion of a second exercise of			that the Emergency prepared	ness		
	choice to test the er	nergency preparedness plan.			plan has conducted exercises			
	Based on interview	at the time of record review,			test the emergency plan.			
	the Executive Direc	ctor agreed that a second			Documentation of these			

exercise of choice was not conducted.

drills/exercises will be reviewed by

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		IDENTIFICATION NUMBER  155243	ì í	JILDING	INSTRUCTION	COMPL 08/04/	ETED
	PROVIDER OR SUPPLIER			300 WII	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Maintenance and the	knowledged by the Director of e Executive Director at the ew and again at the exit o.m.			the quality assurance committe	ee.	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 08/04  Facility Number: 00 Provider Number: 1002  At this Life Safety C Lafayette was found Requirements for Pa Medicare/Medicaid Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa  This one-story facility Type V (111) constructions open to the corridor detectors in all reside facility has a capaci 94 at the time of this	200147 20	K 0	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact request that the plan of correct be considered our allegation of compliance effective 8-26-22 to life safety survey completed on 8-4-2022. We respectfully request a paper review and will provide additional information requested.	cility tion of to the n quest e any	
		residents have customary ered. All areas which provide					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       08/04/2022		
	PROVIDER OR SUPPLIER  IC CARE OF LAFAYETTE	300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	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  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	K 0211	It is the practice of this facility ensure that the means of egre are continuously maintained fr	ess
	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		of all obstructions.  The corrective action taken f those residents found to be affected by the deficient practice includes: There are identified residents	
	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		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 nowere identified. The hoyer lift of the removed and wheelchair was moved from being in front of the exit doors	ne was

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COD SINDY HILL DR YETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  What measures will be put in	DATE
	Maintenance at the observation and aga the Executive Direct Maintenance preser 3.1-19(b)			place and what systemic changes will be made to ensure that the deficient practice does not recur: The equipment was removed from means of egress. All other do were audited and no issues found. All staff were inservice regarding this deficient practice. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place:  The maintenance director and his designee will audit the ent facility daily for 30 days. wee 4 weeks and then monthly thereafter. Findings will be remedied immediately and administrator notified. All findi and discovery will be discussed the quarterly QA meetings. Administrator to monitor	the cors  ed ce.  iii  iity  out  i/or  ire kly x
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING	d means of egress shall not a latch or a lock that f a tool or key from the s using one of the following rangements: S OR SECURITY THREAT king arrangements for the			

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155243		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER			300 WIN	DDRESS, CITY, STATE, ZIP COD IDY HILL DR ETTE, IN 47905			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	]	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	(X5) COMPLETION	
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1	eeds of the patient are						
		cking device shall be						
		door and provisions shall						
		apid removal of occupants						
	_	l of locks; keying of all						
	1	ied by staff at all times; or						
		e means available to the						
	staff at all times.	226 1022251						
		.2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6 SPECIAL NEEDS LOCKING							
	ARRANGEMENT							
		king 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							
	_	at fail safely so as to						
		of power to the device; the						
	building is protect	ed by a supervised						
	automatic sprinkle	er system and the locked						
	space is protected	d by a complete smoke						
	detection system	(or is constantly monitored						
	at an attended loc	ation within the locked						
		the sprinkler and detection						
	*	nged to unlock the doors						
	upon activation.							
	18.2.2.2.5.2, 19.2							
	DELAYED-EGRE							
	ARRANGEMENT							
		lelayed-egress locking						
		in accordance with						
		permitted on door						
		ng low and ordinary hazard ngs protected throughout by						
		ervised automatic fire or an approved, supervised						
	automatic sprinkle	• • • •						
	18.2.2.2.4, 19.2.2	-						
		OLLED EGRESS						
	LOCKING ARRAI							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 08/04/2022			ETED			
		ROVIDER OR SUPPLIER			300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
		installed in accord be permitted.  18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblied throughout by an automatic fire dete approved, supervisystem.  18.2.2.2.4, 19.2.2  1. Based on observation of the facility.  Findings include:  Based on observation of the facility of the facility of the facility of the Surveyor, then tried to open the domaintenance was allopen the exit door. Stated he was award appointment with the on several doors the This finding was according to the Several doors the Severa	BY EXIT ACCESS NGEMENTS t access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an ised automatic sprinkler 7.2.4 ation and interview, the facility exterior exit doors were readily to open on first try. This build affect 25 occupants in the 7.04/22 between 1:00 p.m. and ain dining room exit doors would lay on the first try when tested. the Director of Maintenance or, and the Director of ble, after considerable effort to The Director of Maintenance e of the issue and had an the facility contractor to work roughout the facility. Eknowledged by the Director of time of discovery and ain at the exit conference with eter and Director of	K 0	222	It is the practice of this facility ensure all the exterior exit doc were readily accessible and a to open on first try  The corrective action taken of those residents found to be affected by the deficient practice includes: There are identified residents  How other residents that have the potential to be affected by the deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected but no were identified. The main dining room door has been maintained open freely and easily without excessive pressure. The main door in dining room code has posted and 15 second relay is operational.  What measures will be put in	ors ble  for no ne ng ed to in been	08/19/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G 01	(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER		300	EET ADDRESS, CITY, STATE, ZIP CO ) WINDY HILL DR FAYETTE, IN 47905	D
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFI	CROSS-REFERENCED TO THE API	ULD BE COMPLETION PROPRIATE
K 0293	2. Based on observation failed to ensure the Main dining exit was residents without a specialized security required means of ewith a latch or lock or key from the egrepermitted by LSC 1 arrangements shall with 19.2.2.2.5.2. Taffect over 25, staff the facility.  Findings include:  Based on observation tour of the facility of the facility of Maintenance on 08, 4:30 p.m., the Main marked as a facility and could be opened but the code was not there 15 second delidoor.  This finding was ac Maintenance at the observation and again the Executive Direct Maintenance presert 3.1-19(b)	04/22 between 1:00 p.m. and Dining exit door (1 of 2), exit, was magnetically locked d by entering a four-digit code t posted at the exit nor was ayed egress signage on the knowledged by the Director of time of discovery and in at the exit conference with tor and Director of	TAG	place and what system changes will be made to ensure that the deficier practice does not recur main dining room door homaintained to open freel easily without excessive pressure. The main door room code has been post 15 second relay is operated the exterior exits have assessed and meet regular that the deficient practice will not recur, i.e., what assurance program will into place:  The maintenance direct his designee will audit the facility to ensure that all readily accessible and a open on first try. Mainted designee will audit doors weekly for 4 weeks and weekly for 6 months and thereafter. Any negative will be immediately reme ED informed. All findings brought to the QA meeting Administrator to monitor.	ont T: The las been y and or in dining sted and ational. All been ulation.  on will actice a quality I be put  or and/or he entire doors are ble to mance or so 2x then 1 x I e findings edied and so will be ng.
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directiona	al signs are displayed in			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155243		A. BUILDING B. WING	01	COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR YETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE	
	illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with I where the line of e Based on observation failed to ensure 1 of continuously illuminated affect 6 staff in Findings include:  Based on observation tour of the facility with Maintenance on 08/4:30 p.m., the Exit I Room above the exit Based on an interview Maintenance at the function why the exit I have been supported by the continuously illuminated at the facility with the continuously includes the support of the facility with Maintenance at the facility with the continuously illuminated by the continuously illumina	ess than 30 occupants exit travel is obvious.) on and interview, the facility over 15 exit signs were nated. This deficient practice in the boiler room.  ons and interview during a exit the Director of 04/22 between 1:00 p.m. and ight in the Mechanical /Boiler t door was not illuminated. Exw with the Director of time of observation, it was at sign was not illuminated.  knowledged by the Director of time of discovery and in at the exit conference with tor and Director of	K 0293	It is the responsibility of this facility to ensure that all exit sare continuously illuminated.  The corrective action taken those residents found to be affected by the deficient practice includes: There are identified residents  How other residents that hat the potential to be affected it the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but no were identified. The exit sign above mechanical/boiler room bulb was replaced.  What measures will be put it place and what systemic changes will be made to ensure that the deficient practice does not recur: The sign above mechanical/boiler light bulb was replaced. All of exit lights were audited and a were fully functioning.  How the corrective action we be monitored to ensure the deficient practice.	for e no ve by  one in light nto e exit room ther ill

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIEF			300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					will not recur, i.e., what quality assurance program will be pure into place:	-	
					The maintenance director and his designee will will audit doo 1x weekly x3 months and ther 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.	rs n 1	
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartment patients comply with 30 or fewer proconditions under a Cooking facilities NFPA 96 per 9.2.3	nt is protected in NFPA 96, Standard for and Fire Protection of ing Operations, unless: ng equipment (i.e., small as microwaves, hot plates, if for food warming or limited ance with 18.3.2.5.2, a open to the corridor in ents with 30 or fewer with the conditions under .5.3, or a in smoke compartments attents comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not					

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18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

Based on observation and interview, the facility

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It is the responsibility of this

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/04/2022 155243 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 WINDY HILL DR MAJESTIC CARE OF LAFAYETTE LAFAYETTE, IN 47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure 1 of 1 kitchen range hood facility to ensure that the range extinguishing systems was maintained in proper hood extinguishing system is working order. NFPA 96, 2011 edition, Section maintained and in proper working 10.1.2 requires cooking equipment that produces condition. grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal The corrective action taken for device, or duct shall be protected by those residents found to be fire-extinguishing equipment. Section 11.1.6 states affected by the deficient cooking equipment shall not be operated while its practice includes: There are no fire-extinguishing system or exhaust system is identified residents nonoperational or impaired. This deficient practice was not in a resident area but could affect How other residents that have 6 kitchen staff. the potential to be affected by the same defective practice Findings include: will be identified and what corrective action will be Based on observations and interview during a taken. All residents have the tour of the facility with the Director of potential to be affected but none Maintenance on 08/04/22 between 1:00 p.m. and were identified. The nozzles were 4:30 p.m., the kitchen range hood extinguishing realigned with the cooking system nozzles (4 of 4 over 2 different appliances) equipment and are correctly were not properly positioned over the cooking positioned. equipment under the hood. All nozzles were What measures will be put into pointed straight down but the cooking equipment place and what systemic orientation did not align with the direction of the changes will be made to nozzles. The Director of Maintenance agreed that ensure that the deficient the nozzle direction did not match the appliance practice does not recur: The locations. nozzles of the range hood extinguishing system were This finding was acknowledged by the Director of realigned with the cooking Maintenance at the time of discovery and equipment and are correctly observation and again at the exit conference with positioned. the Executive Director and Director of Maintenance present at 5:00 p.m. How the corrective action will be monitored to 3.1-19(b) ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
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NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE		STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
V 0246	NEDA 404			The maintenance director and/his designee will will audit rang hood system 1x weekly x3 months and then 1 x monthly 3 months Any negative finding will be immediately remedied a ED informed. All findings will b brought to the QA meeting. Administrator to monitor.	for gs and
K 0346 SS=C Bldg. 01	services for more period, the author be notified, and th evacuated or an a provided for all pa	f Service re alarm system is out of than 4 hours in a 24-hour ity having jurisdiction shall e building shall be approved fire watch shall be rties left unprotected by the e fire alarm system has			
	failed to provide a c for the protection of procedures to be for alarm system has to four hours or more	view and interview, the facility complete 1 of 1 written policy f residents indicating flowed in the event the fire to be placed out of service for in a twenty four hour period in the C, Section 9.6.1.6. This feets all occupants.	K 0346	It is the responsibility of this facility to ensure a written police for the protection of residents indicating procedures to be followed in the event the fire all system has to be placed out of service for four hours or more 24 hour period.	larm f
	Director of Mainter Director on 08/04/2 p.m., the fire watch	eview and interview with the nance and the Executive 2 between 10:15 a.m. and 1:00 plan failed to include		The corrective action taken for those residents found to be affected by the deficient practice includes: There are identified residents	no
	contacting the India	na Department of Health via	1	How other residents that have	e l

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the ISDH Gateway link at

https://gateway.isdh.in.gov as the primary method

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the potential to be affected by

the same defective practice

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/04/2022
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COI INDY HILL DR 'ETTE, IN 47905	)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CITION (X5)  JLD BE PROPRIATE COMPLETION DATE
	Gateway is nonope Incident Reporting incidents@isdh.in.g  Based on interview Director of Mainter watch documentate the Indiana State D number, and not via the e-mail address I  This finding was ac Maintenance and the	during the record review, the nance acknowledged the fire on provided stated to contact epartment of Health at a phone a the ISDH Gateway link or at isted above.  Eknowledged by the Director of the Executive Director at the iew and again at the exit		will be identified and will corrective action will be taken. All residents have potential to be affected be were identified. The fire updated to include to not ISDH via gateway if there disruption in the fire alarmand it is out of service for hours in a 24 hour period gateway portal isn't open incident reporting form memailed or faxed.  What measures will be place and what systemic changes will be made to ensure that the deficient practice does not recurplan was updated to including the ISDH via gatewing the ISDH via gatewing the is a disruption in the alarm system and it is out service for four hours in a period. If the gateway properational an incident reform must be emailed or the monitored to ensure the deficient prawill not recur, i.e., what assurance program will into place:  The executive director and designee will review the disaster plan at least mo update any changes that be made. The disaster previewed quarterly in the	e the out none plan was tify the e is a m system of the ational an analyst be put into ic count of the ational analyst be if the ational analyst be put into a the ational analyst be put into a the ational analyst be into a the ational analyst be into a the ational analyst be ational analyst be at a the ational analyst be ational analys

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155243		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/04/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  300 WINDY HILL DR  LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				meetings and signed by attendees. Administrator to monitor.		
K 0353 SS=E Bldg. 01	Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAR coverage for any a automatic sprinkle 9.7.5, 9.7.7, 9.7.8  Based on observation failed to maintain the throughout the faciliand gases around the sprinkler to operate	supply source  RKS information on non-required or partial er system.	K 0353	It is the practice of this facility maintain the ceiling construction throughout the facility  The corrective action taken for those residents found to be	on	
	distance between th ceiling above shall of sprinkler and the	e sprinkler deflector and the be selected based on the type type of construction. This buld affect 6 residents and 3		affected by the deficient practice includes: There are identified residents	no	
	staff. Findings include:			How other residents that hav the potential to be affected b the same defective practice will be identified and what		
	Based on observation	ons and interview during a		corrective action will be		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/04/2022
	PROVIDER OR SUPPLIER		300 W	ADDRESS, CITY, STATE, ZIP COD INDY HILL DR /ETTE, IN 47905	
(X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER OF TH	the ut none around linen COMPLETION DATE	
	the sprinkler head.  This finding was ac Maintenance at the	knowledged by the Director of time of discovery and hin at the exit conference with stor and Director of		changes will be made to ensure that the deficient practice does not recur: around the sprinkler head repaired and maintained. facility tour was complete there were no other findir obstructions from the sprinkeads.	t The gap d was A full d and
				How the corrective action be monitored to ensure the deficient practical will not recur, i.e., what assurance program will into place:	ctice quality be put
				The maintenance director his designee will audit the facility to ensure that the in full repair and there are obstructions and gaps. At be conducted monthly x6 and quarterly thereafter. findings will be immediate remedied and brought to attention of the ED. Find be discussed at the quart meetings.	e entire ceiling is e no udit will months All ely the ings will
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System Sprinkler System				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUI		X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	01	COMPL	
		155243	B. W.		<u> </u>	08/04/	
						30,01,	= - <b></b>
NAME OF P	ROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
MA IESTI	C CARE OF LAFA	VETTE	300 WINDY HILL DR LAFAYETTE, IN 47905				
IVIAJESTI	O CARE OF LAFA	ICIIC		LAFAYI	ETTE, IN 47900		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Where the sprinkler system is impaired, the						
		n of the impairment has					
	been determined, areas or buildings involved						
	<u> </u>	risks are determined,					
	recommendations						
	-	esignated representative,					
	-	tment and other authorities					
		have been notified. Where					
		em is out of service for more					
		24-hour period, the of the building affected are					
	• •	<u> </u>					
	evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.						
		, 9.7.5, 15.5.2 (NFPA 25)					
		view and interview, the facility	$ _{K0}$	354	It is the responsibility of this		08/18/2022
		of 1 correct written policies in		facility to ensure a written pol		су	10.10.2022
	-	atic sprinkler system has to be			for the protection of residents	-	
		ce for 10 hours or more in a			indicating procedures to be		
	24-hour period in a	ccordance with LSC, Section			followed in the event the autor	matic	
	9.7.5. LSC 9.7.6 red	quires sprinkler impairment			sprinkler system has to be pla	ced	
	procedures comply	with NFPA 25, 2011 Edition,			out of service for 10 hours or i	more	
		Inspection, Testing and			in a 24 hour period.		
		ter-Based Fire Protection					
	•	, 15.5.2 requires nine			The corrective action taken f	or	
	-	impairment coordinator shall			those residents found to be		
		(b) states a fire watch should			affected by the deficient		
	_	ersonnel who continuously			practice includes: There are	no	
	•	area. Ready access to fire ne ability to promptly notify			identified residents		
	_	are important items to			How other residents that have	<b>10</b>	
	•	e patrol of the area, the person			the potential to be affected by		
	_	looking for fire, but making			the same defective practice	'y	
	_	ire protection features of the			will be identified and what		
		ress routes and alarm systems			corrective action will be		
		nctioning properly. This			taken. All residents have the		
		ould affect all occupants in the			potential to be affected but no	ne	
	facility.	r			were identified. The fire plan		
					updated to include to notify the		
	Findings include:				ISDH via gateway if there is a		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE ( A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/04/2022	
MAJEST	PROVIDER OR SUPPLIER	YETTE	300 W LAFA	FADDRESS, CITY, STATE, ZIP COD /INDY HILL DR YETTE, IN 47905	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  TAG  DEFICIENCY)  CCC	
	Director of Maintern Director on 08/04/2 p.m., the fire watch contacting the India the ISDH Gateway https://gateway.isdh or by the secondary Gateway is nonoper Incident Reporting incidents@isdh.in.g  Based on interview Director of Maintern watch documentation the Indiana Departm number, and not viathe e-mail address I  This finding was ac Maintenance and the time of records reviconference at 5:00 p.  3.1-19(b)	atin.gov as the primary method method when the ISDH rational by completing the form and e-mailing it to gov.  during the record review, the rance acknowledged the fire on provided stated to contact ment of Health at a phone at the ISDH Gateway link or at isted above.  knowledged by the Director of the Executive Director at the ew and again at the exit		disruption in the sprinkler sy and it is out of service for ter hours in a 24 hour period. If gateway portal isn't operatio incident reporting form must emailed or faxed.  What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur: To plan was updated to include notify the ISDH via gateway there is a disruption in the sprinkler system and it is our service for ten hours in a 24 period. If the gateway porta operational an incident report form must be emailed or fax.  How the corrective action was monitored to ensure the deficient practice will not recur, i.e., what quassurance program will be into place:  The executive director and/or designee will review the fire disaster plan at least monthly update any changes that need to made. The disaster plan reviewed quarterly in the QA meetings and signed by attendees. Administrator to monitor.	in the mal an be into into into into into into into into
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 08/04/2022			ETED		
		133243	D. W	_		00/04/	2022
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF LAFA	YETTE			NDY HILL DR ETTE, IN 47905		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		corridor openings in other					
	1	losures of vertical openings,					
		is areas resist the passage					
		made of 1 3/4 inch					
		wood or other material ng fire for at least 20					
	1	fully sprinklered smoke					
		e only required to resist the					
		e. Corridor doors and doors					
	to rooms containii						
		rials have positive latching					
	hardware. Roller latches are prohibited by						
	CMS regulation. These requirements do not						
	1	spaces that do not contain					
	flammable or com						
		en bottom of door and floor					
	_	ceeding 1 inch. Powered					
		with 7.2.1.9 are permissible					
	I	device capable of keeping					
		hen a force of 5 lbf is no impediment to the					
		rs. Hold open devices that					
	1	door is pushed or pulled are					
		ed protective plates of					
	1 ·	re permitted. Dutch doors					
	1	6 are permitted. Door					
	· ·	beled and made of steel or					
	other materials in	compliance with 8.3,					
	unless the smoke	compartment is					
		fire window assemblies are					
	•	n sprinklered compartments					
		ctions in area or fire					
	1	s or frames in window					
	assemblies.						
	10363 42 050	Parts 403, 418, 460, 482,					
	483, and 485	1 41.6 700, 710, 700, 702,					
		(S details of doors such as					
		ngs, automatics closing					
	devices, etc.	3					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE		ETED		
		155243	B. WING 08/04/2022		/2022		
				GENEER	A DODDEGG CHTM CTATE THE COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF LAFA	VETTE			NDY HILL DR		
MAJESI	IC CARE OF LAFA	TELLE		LAFAT	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		ation and interview, the facility	K 0	363	It is the practice of this facility	to	08/25/2022
		corridor doors had no			ensure all corridor doors have	no	
	_	ing and latching into the door			impediment to closing and		
		sist the passage of smoke.			latching into the door frame.		
	This deficient practice could affect 6 staff and 15						
	residents.						
					The corrective action taken f	or	
	Findings include:				those residents found to be		
					affected by the deficient		
		ons and interview during a			practice includes: There are	no	
	tour of the facility v				identified residents		
	Maintenance on 08/04/22 between 1:00 p.m. and				l		
	4:30 p.m., the following corridor doors failed to latch positively into their respective door frames:				How other residents that have		
		•			the potential to be affected b	У	
		ors near the kitchen, equipped			the same defective practice		
	with latching hardw				will be identified and what		
		ors to the Lounge on Cedar			corrective action will be		
		n a door coordinator. om on Cedar Hall near resident			taken. All residents have the		
	c) The Linen Roo room 231.	on Cedai Han hear resident			potential to be affected but no		
		andry corridor door, equipped			were identified. The following doors have been adjusted, or	listed	
	with a self-closing				maintained and properly latch	into	
	_	oset near resident room 108,			the door frame.	IIIO	
	equipped with a sel				The double doors near th	10	
		ors to the Lounge on B-1,			kitchen, equipped with latching		
	equipped with a do				hardware.	9	
		ity corridor door on B-3, the			The double doors to the Loung	ae on	
	1	plastic bags stuffed into the			Cedar Hall, equipped with a de	_	
		door from latching.			coordinator.		
		C			The Linen Room on Cedar Ha	ıll	
	This finding was ac	knowledged by the Director of			near resident room 231.		
	_	time of discovery and			The Clean Laundry corridor do	oor,	
		ain at the exit conference with			equipped with a self-closing	•	
		ctor and Director of			device.		
	Maintenance preser	nt at 5:00 p.m.			The Linen Closet near residen	nt	
					room 108, equipped with a		
	2. Based on observa	ation and interview, the facility			self-closing device.		
	failed to ensure 1 or	f over 30 corridor doors would			The double doors to the Loung	ge on	
	resist the passage of	f smoke. This deficient			B-1, equipped with a door		
	practice could affect	et 12 residents.			coordinator.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  08/04/2022			TED	
	PROVIDER OR SUPPLIEF		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR 'ETTE, IN 47905		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	Findings include:  Based on observation of the facility of the facility of Maintenance on 08, 4:30 p.m., the followhich penetrated control of the Corridor B. The Pantry Stockhole as a result of the additionally the document of the Maintenance at the	wing corridor doors had holes completely through the door: ity on Cedar Hall had a 2 inch door. orage door in the Kitchen had a he door knob being broken, or was propped open. eknowledged by the Director of time of discovery and ain at the exit conference with eter and Director of	TAG	The Dirty Utility corridor door B-3, the latch had paper and plastic bags stuffed into the jat to prevent the door from latch.  The following two doors have replaced or corrected to prevent the passage of smoke.  The Dirty Utility on Cedar Hall a 2 inch hole in the corridor do The Pantry Storage door in the Kitchen had a hole as a result the door knob being broken, additionally the door was propopen.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: A furnitude audit of the facility found that other doors were deficient of the practice.  How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place:  The maintenance director and his designee will audit the entifacility to ensure that all fire do are properly latching and meeting federal regulations. Corridor audits will be completed week	on amb ing. been ent I had oor. le t of oped III no this III e ity out	DATE

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4 weeks then monthly times 3

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		A. BUILDING	PLE CONSTRUCTION (X3) DATE SURVEY		
	PROVIDER OR SUPPLIER		300	ET ADDRESS, CITY, STATE, ZIP COD WINDY HILL DR AYETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				months then quarterly times quarters. All findings will be immediately remedied and b to the QA meeting. Administ to monitor findings	rought
K 0374 SS=F Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that r Nonrated protection are permitted. Doof fixed fire window a are self-closing or require latching, a in the direction of provides a minimulator swinging or ho 19.3.7.6, 19.3.7.8 1. Based on observa	resists fire for 20 minutes. The plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening am clear width of 32 inches rizontal doors.  19.3.7.9  This is a sum of the plate	K 0374	It is the responsibility to ensu	re 08/18/2022
	would restrict the m 20 minutes. LSC 1	f 8 sets of smoke barrier doors novement of smoke for at least 9.3.7.8 requires doors in smoke by with LSC Section 8.5.4. LSC		the smoke barrier doors will restrict the movement of smo at least 20 minutes.	oke for
	8.5.4.1 requires doc the opening leaving	ors in smoke barrier shall close only the minimum clearance r operation. This deficient		The corrective action taken those residents found to be affected by the deficient practice includes: There are identified residents	
		ons and interview during a vith the Director of		How other residents that hat the potential to be affected the same defective practice	by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01		(X3) DATE SURVEY COMPLETED		
		155243	B. WIN	IG		08/04/2022	
	PROVIDER OR SUPPLIEF		•	STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	Maintenance on 08/	/04/22 between 1:00 p.m. and			will be identified and what		
	4:30 p.m., the follow	wing smoke doors failed to			corrective action will be		
	close properly:				taken. All residents have the		
	a) The double do	ors leading from the service			potential to be affected but no	ne	
	hall into the main c	orridor did not self-close and			were identified. The double do		
	latch.				leading from the service hall ir	nto	
	b) The double do	ors near the main lobby			the main corridor self-closes a	ınd	
	leading into the cor	ridor did not self-close and			latches correctly.		
	latch.				The double doors near the ma	in	
	c) The double do	ors near the beauty shop did			lobby leading into the corridor		
	not self-close and la	atch.			self-close and latch correctly.		
					The double doors near the bea	auty	
	This finding was acknowledged by the Director of				shop self-close and latch.		
		time of discovery and			The felt astragal was replaced	lon	
		ain at the exit conference with			the door by ambulance entran	ce	
	the Executive Direc	etor and Director of			and 1/2 inch gap was correcte	ed.	
	Maintenance preser	nt at 5:00 p.m.			The attic hatch door was close	ed	
					and secured.		
					What measures will be put in	ito	
		ation and interview, the facility			place and what systemic		
		f 8 sets of smoke barrier doors			changes will be made to		
		novement of smoke for at least			ensure that the deficient		
		101 2012 19.3.7.8 requires			practice does not recur: The		
		riers shall comply with LSC			double doors leading from the		
		8.5.4.1 requires doors in smoke			service hall into the main corri		
		he opening leaving only the			self-closes and latches correc	-	
		e necessary for proper operation			The double doors near the ma		
		1/8 inch. This deficient			lobby leading into the corridor		
	-	et 20 residents in two smoke			self-close and latch correctly.		
	compartments				The double doors near the bea	auty	
	F: 1: : 1 1				shop self-close and latch.		
	Finding include:				The felt astragal was replaced		
	D11	1:-4:			the door by ambulance entran		
		ons and interview during a			and 1/2 inch gap was correcte		
	tour of the facility v				The attic hatch door was close		
		/04/22 between 1:00 p.m. and			and secured. All other doors w	vere	
	_	te barrier doors entering the			audited and met federal		
		ce had a 1/2 inch gap between			guidelines.		
		sed. The felt astragal on one					
	side was missing. B	Based on an interview at the	1		How the corrective action wi	II	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155243		A. BUILDING B. WING	01	COMPLETED 08/04/2022	
	ROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR 'ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	time of observation, agreed there was a g between the smoke astragal being missi.  This finding was ach Maintenance at the observation and agathe Executive Direct Maintenance presents.  3. Based on observation and agathe Executive Direct Maintenance presents.  3. Based on observation at least 20 requires doors in sm. LSC Section 8.5.4. smoke barrier shall the minimum cleara operation. This defires idents.  Findings include:  Based on observation tour of the facility will Maintenance on 08/4:30 p.m., the smoke maintenance was printerview during the Director of Maintenhatch smoke barrier stated to his knowled the attic.  This finding was ach Maintenance at the state of the smoke as a second maintenance at the state of the smoke at the smo	the Director of Maintenance gap larger than 1/8 inch doors when closed due to the ng on one side.  knowledged by the Director of time of discovery and in at the exit conference with tor and Director of it at 5:00 p.m.  tion and interview, the facility over 6 ceiling smoke barrier ould restrict the movement of minutes. LSC 19.3.7.8 toke barriers shall comply with LSC 8.5.4.1 requires doors in close the opening leaving only nee necessary for proper icient practice affects all  ons and interview during a with the Director of 04/22 between 1:00 p.m. and to barrier attic hatch near the opped open. Based on the time of observations, the ance acknowledged the attic door was not closed and dge no one was working in the consequence of discovery and		be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be p into place: The maintenance director and his designee will audit the end facility to ensure that all smok barrier doors restrict the movement of smoke for at lea minutes. Maintenance or des will audit doors 2x weekly for weeks and then 1 x weekly for months and thereafter. Any negative findings will be immediately remedied and El informed. All findings will be brought to the QA meeting. Administrator to monitor.	d/or tire se ast 20 ignee 4
	the Executive Direc Maintenance presen				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155243 B. WING 08/04/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 WINDY HILL DR MAJESTIC CARE OF LAFAYETTE LAFAYETTE. IN 47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 3.1-19(b) K 0511 **NFPA 101** SS=E Utilities - Gas and Electric Bldg. 01 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 K 0511 It is the responsibility of this 08/12/2022 failed to ensure 1 of over 10 wet locations were facility to ensure wet locations are provided with ground fault circuit interrupter provided with ground fault circuit (GFCI) protection against electric shock. LSC interrupter protection. 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment The corrective action taken for to comply with NFPA 70, National Electrical Code. those residents found to be NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault affected by the deficient Circuit-Interrupter Protection for Personnel, practice includes: There are no states, ground-fault circuit-interruption for identified residents personnel shall be provided as required in 210.8(A) through (C). The ground-fault How other residents that have the potential to be affected by circuit-interrupter shall be installed in a readily accessible location. the same defective practice (B) Other Than Dwelling Units. All 125-volt, will be identified and what single-phase, 15- and 20-ampere receptacles corrective action will be installed in the locations specified in 210.8(B)(1) taken. All residents have the

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(1) Bathrooms

(2) Kitchens

(3) Rooftops

(4) Outdoors

through (8) shall have ground-fault

circuit-interrupter protection for personnel.

not readily accessible and are supplied by a

Exception No. 1 to (3) and (4): Receptacles that are

branch circuit dedicated to electric snow-melting,

deicing, or pipeline and vessel heating equipment

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potential to be affected but none

were identified. The ice machine

is now plugged into a GFCI outlet.

The electrical box in kitchen with

What measures will be put into

exposed wires was maintained

and cover was replaced.

place and what systemic

changes will be made to

ensure that the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE		ETED		
		155243	B. WING 08/04/2022			2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
MAJESTI	C CARE OF LAFA	YEIIE		LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROP		IE	DATE
	shall be permitted to be installed in accordance				practice does not recur: The	ice	
	with 426.28 or 427.				machine is now plugged into a		
		(4): In industrial establishments			GFCI outlet. The electrical box		
	_	ditions of maintenance and			kitchen with exposed wires wa		
	_	that only qualified personnel			maintained and cover was	3	
	_	ured equipment grounding			replaced. All other wet areas	vere	
		as specified in 590.6(B)(2)			audited and all met requiremen		
		or only those receptacle			of this regulation.	ii3	
	-	ly equipment that would			or una regulation.		
		ard if power is interrupted or			How the corrective action wil		
		t is not compatible with GFCI			be monitored to	•	
	protection.	is not compandic with Gr Cr			ensure the deficient practice		
	•	ceptacles are installed within			will not recur, i.e., what quali		
		outside edge of the sink.			_	-	
		(5): In industrial laboratories,			assurance program will be po	aι	
	-	supply equipment where			into place:		
	_	yould introduce a greater			The mediate was a discrete and	/	
	-	<del>-</del>			The maintenance director and		
	_	nitted to be installed without			his designee will review all we	<u>.</u>	
	GFCI protection.	(5). F			areas weekly x3 months and		
	_	(5): For receptacles located in			monthly x3 months to assure a	all	
	-	s of general care or critical			wet areas are secure. Any		
		care facilities other than those			negative findings will be		
	covered under				immediately remedied and bro	_	
		protection shall not be required.			to the administrator. Findings		
	(6) Indoor wet locat				be brought to the quarterly QA	Ą	
		rith associated showering			meetings and signed by		
	facilities				attendees. Administrator to		
		bays, and similar areas where			monitor.		
		e equipment, electrical hand					
	tools.						
		Vet Locations, requires all					
	_	ed equipment within the area of					
		nave ground-fault circuit					
		protection. Note: Moisture can					
		esistance of the body, and					
		is more subject to failure.					
	_	ice could affect staff and up to					
	4 residents while at	the ice machine.					
	Findings include:						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155243		A. BUILDING B. WING	01	COMPI 08/04		
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	tour of the facility we Maintenance on 08/4:30 p.m., the ice me was connected to an being used to power with it's own water a located within 3 fee not provided with general ground of observation states receptacle was on a servation and agast the Executive Direct Maintenance present 2. Based on observation and agast the Executive Direct Maintenance present 2. Based on observation and agast the Executive Direct Maintenance present 1 of 1 electric maintained in a safet 19.5.1.1 requires utility LSC 9.1.2 requires to comply with NFF NFPA 70, 2011 Ediction boxes shall compatible with the conditions of use. Vec comply with the ground provided the provided in the kitchen area.  Findings include:  Based on observation of the facility we Maintenance on 08/10.	04/22 between 1:00 p.m. and achine in the soda machine area a electric receptacle which was a the freestanding ice machine, supply. The ice machine was to of the electric receptacle, and round fault circuit interruption for of Maintenance at the time of the did not believe the GFCI circuit.  knowledged by the Director of time of discovery and in at the exit conference with tor and Director of that at 5:00 p.m.  Attion, the facility failed to cal boxes in the kitchen were experating condition. LSC electrical wiring and equipment PA 70, National Electrical Code. Ition, Article 314.28(3) (c) states be provided with covers box and suitable for the Where used, metal covers shall bunding requirements of the constant of the practice could affect 6 staff				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU  AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLET  155243 B. WING 08/04/20	TED
100240 B. WING U8/04/20	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE  STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	(X5) COMPLETION DATE
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 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	08/12/2022

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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

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corrective action will be

taken. All residents have the

potential to be affected but none

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 08/04/2022				
	ROVIDER OR SUPPLIER		300 \	STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5)  JLD BE PROPRIATE COMPLETION DATE			
	except for hospitals 6 years. If the damplink, the link shall be full closure and lock damper shall not be way. All inspection documented, indicated damper, date of inspection deficiencies discover have a space to indicate deficiencies were compactice could affect brindings include:  Based on observation tour of the facility of Maintenance on 08/4:30 p.m., in the So HVAC vent was missen stuffed into the HVAC Damper. Resmoke damper inspection of Maintenance states the Social Services and was attempting.  This finding was ac Maintenance at the	where the frequency is every per is equipped with a fusible per removed for testing to ensure ex-in-place if so equipped. The blocked from closure in any as and testing shall be ting the location of the fire pection, name of inspector and pered. The documentation shall cate when and how the perceted. This deficient that 3 staff.  The documentation shall cate when and how the perceted. This deficient that 3 staff.  The documentation shall cate when and how the perceted. This deficient that 3 staff.  The documentation shall cate when and how the perceted. This deficient that 3 staff.  The documentation shall cate when and how the perceted. This deficient that 3 staff.  The documentation shall cate when and how the percetor of the ceiling sain a cover. Insulation had the vent which contained a percetor which contained a percetor which contained a percetor that perhaps someone in the office was either to hot or cold to manage the airflow.  The documentation shall be the percetor of time of discovery and the perhaps with the perhaps		were identified. The instance was removed from damp social service office.  What measures will be place and what systemichanges will be made to ensure that the deficient practice does not recur insulation was removed damper in the social service. All other dampers inspected and met regulated to ensure the deficient prawill not recur, i.e., what assurance program will into place:  The maintenance director his designee will review a dampers weekly x3 month monthly x3 months to as dampers are properly mathematically remedied are to the administrator. Find the brought to the quarted meetings and signed by attendees. Administrator monitor.	put into ic o it : The from the vice s were ation.  on will  actice quality I be put  or and/or all ths and sure all aintained. Il be and brought dings will erly QA			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include	the transmission of a fire						

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RJES21 Facility ID: 000147

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DENTIFICATION NUMBER 155243  MAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE  (AM ID SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  FREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR  LAFAYETTE, IN 47995  (AM ID SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID STREAM)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID STREAM)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID STREAM)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  LAFAYETTE, IN 47995  (AX)  COMPLETION  TAG (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  LAFAYETTE, IN 47995  (AX)  COMPLETION  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  LAFAYETTE, IN 47995  (AX)  COMPLETION  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  SUMMARY STATEMENT OF DEFICIENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF DEFICENCIE (AM ID BREAK)  TAG (AM ID BREAK)  SUMMARY STATEMENT OF THE AM IN TAG (AM ID BREAK)  SUMMARY STATEMENT OF THE AM IN TAG (AM ID BREAK)  SUMMARY STATEMENT OF THE AM IN TAG (AM ID BREAK)  STREET ADDRESS. CITY, STATE, ZIP COD 300 WINDY HILL LAR PAYETTE (AM ID BREAK)  TAG (AM ID BREAK)  STREET ADDRESS. CITY, STATE, ZIP COD 300 WINDY HILL LAR PAYETTE (AM ID BREAK)  SUMMARY STATEMENT OF THE AM IN TAG (AM ID BREAK)  STREET ADDRESS. CITY, STATE, ZIP COD 300 WINDY HILL LAR PAYETTE, IN 47995  LAFAYETTE,	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY	
MAJESTIC CARE OF LAFAYETTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (CACTI DEFICURITY MUST HE PRECEDED BY THILL PRECEDED BY THILL PRICE OF LAFAYETTE, IN 47905  Alarm signal and simulation of emergency fire conditions. Fire diffuls are held at expected and unexpected times under varying conditions. Fire diffuls are part of established routine. Where diffuls are part of established routine. Where diffuls are posted as the expected announcement may be used instead of audithle alarms.  19.7.1.4 through 19.7.1.7  Plased 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 80.9422 between 10.15 a.m. and 1:00 p.m. s 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)  SIMMARY STATEMENT OF DEFICIENCE  LAFAYETTE, IN 47905  DEPRIVENCE STATE, STATE, ZIP COD 300 WIND HILL DR. LAFAYETTE, IN 47905  ID PROVIDES FLANOF COMPLICATION DATE OF THE PROVIDED STATES OF THE PROVIDED	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	<u> </u>		COMPLETED
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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 pant 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.  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.  What measures will be but into place and what systemic changes will be put into place and what systemic changes will be put into place and what systemic changes will be put into place and what systemic changes will be put into place and what systemic changes will be put into place and what systemic changes will be put into place and what systemic changes will be put into place and what systemic changes will be put into place. The maintenance					CROSS-REFERENCED TO THE APPRO	PRIATE
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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:  Findings include:  The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents that have the potential to be affected by the optential 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 near the time of records review and again at the exit conference at 5:00 p.m.  3.1-19(b)  Tit is the responsibility of this facility to conduct quarterly fire drills to enducted times under varying conditions.  K 0712  It is the responsibility of this facility to conduct quarterly fire drills were to endit the normal transposed to the specified 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 that have the potential to be affected by 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 by the potential to be affect						
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJES21 Facility ID: 000147

If continuation sheet Page 49 of 58

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/29/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES		B NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/04/2022		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD  300 WINDY HILL DR  LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re e	(X5) COMPLETION DATE	
				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 qualit assurance program will be purinto place:  The maintenance director and/his designee will conduct mont fire drills that are on different s and staggered throughout the month, quarter and year. The times will also be staggered through a 24 hour period so the all dont' fall at the same time of the same shift. Drills will be brought to the quarterly QA meetings for review and signed attendees. Administrator to	ty ut /or thly hifts ey n		
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib used or stored an location, and such signs that read NO			monitor.			

FORM CMS-2567(02-99) Previous Versions Obsolete

smoking.

(2) In health care occupancies where smoking is prohibited and signs are

Event ID:

RJES21

Facility ID: 000147

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPLETED	
155243			B. WING 08/04/2022				
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD NDY HILL DR		_
MAJESTI	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
IAU	prominently place secondary signs v smoking shall not (3) Smoking by paresponsible shall I (4) The requireme apply where the p supervision. (5) Ashtrays of no safe design shall I where smoking is (6) Metal contained devices into which shall be readily av smoking is permitt 18.7.4, 19.7.4 Based on observation failed to ensure 1 of maintained by dispoor noncombustible cover devices. This staff and 10 staff.  Findings include:  Based on observation of the facility with Maintenance on 08.4:30 p.m., in the New Cigarette butts on the facility. The design additional 50 feet fra forementioned cig Maintenance stated staff not going to the which is farther away in the secondary signs and the same stated staff not going to the which is farther away in the secondary signs and the same stated staff not going to the which is farther away in the secondary signs and the same stated staff not going to the which is farther away in the secondary signs and the same stated staff not going to the which is farther away in the secondary signs and the secondary signs and the secondary signs and the secondary signs are secondary signs and the secondary signs are secondary signs and secondary signs and secondary signs are secondary signs are secondary signs and secondary signs are secondary signs and secondary signs are secondary signs are secondary signs are secondary s	d at all major entrances, with language that prohibits be required. atients classified as not be prohibited. Into f 18.7.4(3) shall not atient is under direct uncombustible material and be provided in all areas permitted. It is with self-closing cover in ashtrays can be emptied vailable to all areas where ted.  In and interview; the facility if 1 smoking areas were osing cigarette butts in a metal container with self-closing deficient practice could affect one and interview during a with the Director of 104/22 between 1:00 p.m. and the Ambulance Entrance to be between 75 and 100 are ground near the building, in a tin the trach can near the ated smoking area was an from the location of the arette butts. The Director of that it was likely the result of the designated smoking area, any from the building.	K 0		It is the responsibility of this facility to ensure all smoking areas are maintained by disponsible container with self-closing cover.  The corrective action taken to those residents found to be affected by the deficient practice includes: There are identified residents  How other residents that has the potential to be affected by the deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected but no were identified. The cigarette butts have been cleaned and thrown in appropriate contains	for no ve by	08/19/2022
This finding was acknowledged by the Director of				All staff have been inserviced	on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/04/2022		
	PROVIDER OR SUPPLIER		2	300 WIN	DDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	Maintenance at the	time of discovery and in at the exit conference with tor and Director of		IAU	smoking areas and where to dispose of cigarette butts.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The cigarette butts have been cleand thrown in appropriate container. All staff have been inserviced on smoking areas where to dispose of cigarette butts.  How the corrective action whose monitored to ensure the deficient practice will not recur, i.e., what quant assurance program will be into place:  The maintenance director and his designee will walk ground 3xweekly for 1 month, 2 x we for 1 month and weekly for 4 months and continue. Any negative findings will be immediately remedied and but to the administrator. All staff continue to be inserviced if negative findings occur. Find will be brought to the quarter QA meetings and signed by attendees. Administrator to monitor.	ne aned n and rill e lity out d/or ls eekly rought will ings	DATE
K 0914 SS=F Bldg. 01	Testing	s - Maintenance and					

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STATEMENT OF DEFICIENCIES X1 AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE CO A. BUILDING B. WING			SURVEY ETED 2022		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE			300 WI	STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE		
140	Testing Hospital-grade recolocations and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not list these locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visit LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99) Based on record reviewing at all resider review in accordance Health Care Facilities 6.3.4.1.3 states received hospital-grade at pal locations where decanesthesia shall be exceeding 12 month Facilities Code, 201 states hospital-grade performed after init servicing of the device in the containing of the device of the states and the servicing of the device of the states hospital-grade performed after init servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the states and the servicing of the device of the servicing of the servic	ceptacles at patient bed are deep sedation or general clinistered, are tested after replacement or servicing. It is performed at intervals ented performance data. It is sted as hospital-grade at the tested at intervals not entertal intervals of the sted at intervals less and sted at intervals less at intervals less and sted at intervals less and sted at intervals less and sted at intervals less	K 0914	It is the practice of this facility complete an electrical outlet receptacle testing program on every 12 months and sure documentation of all patient be locations.  The corrective action taken to those residents found to be affected by the deficient practice includes: There are identified residents  How other residents that have the potential to be affected by	ce ed for no	08/18/2022		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIEI		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	confirmed by visual the grounding circushall be verified. Coneutral connections shall be confirmed; grounding blade of (except locking-typt than 115 grams (4 of states, at a minimum date, the rooms or a of which items have the performance rear This could affect all Findings include:  Based on review of completed, document Maintenance and the own of the Director of Maintenance of the testing but receptacles was not or anytime prior to the COVID-19 Pan This finding was act Maintenance and the difference of the Maintenance and the Maintenance and the Maintenance and the Maintenance and the shall be verified.	The tells report of inspections entation with the Director of the Executive Director on 10:15 a.m. and 1:00 p.m., an inspection and testing electrical was not available for review. The time of record review, at the time of record review, not an accommentation simply stated in iteration of Maintenance had at an itemized list of rooms and available for the current year January 2020 and the onset of demic.  Exhaust Charles are provided by the Director of the Executive Director at the item and again at the exit		the same defective practice will be identified and what corrective action will be take Potentially all residents could affected but none were identificated an electrical outlet receptacle test was completed all patient bed locations with documentation.  What measures will be put implace 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 be locations.  How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  The maintenance director and his designee will complete and receptacle test at all patient beds. Results of negative test be immediately communicated administrator. Results then brought to QA committee meeting. Administrator to monifindings	be ded. If at  Ity  ut  /or  nual  it will It to

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155243		r í	JILDING	01	COMPL 08/04/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vio non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3( 1. Based on observa failed to ensure 4 of as a substitute for fir equipment with a hi NFPA-70/2011, 400 permitted in 400.7 f not be used for (1) a	d electrical equipment es that have been lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), n care resident rooms that E. Power strips for PCREE UL 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension I as a substitute for fixed e. Extension cords used moved immediately upon curpose for which it was s the conditions of 10.2.4. D), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 tion and interview, the facility 4 power strips were not used ked wiring to provide power	K 0	920	It is the practice of this facility to ensure that power strips and extension cords are not used for substitute for fixed wiring.  The corrective action taken for those residents found to be affected by the deficient practice includes: There are identified residents	or a	08/18/2022

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155243		B. WING 08/04/2022			2022		
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	L			NDY HILL DR		
MA IEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
IVIAJEST	OANE OF LAFA	ILIIC		LAFATI	LIIL, IIN 47 300		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ons and interview during a			How other residents that have		
	tour of the facility v				the potential to be affected b	у	
		04/22 between 1:00 p.m. and			the same defective practice		
		trip were being used to power a			will be identified and what		
	high power draw eq	uipment:			corrective action will be		
					taken. All residents have the		
		Records Office - a dorm style			potential to be affected but no		
	refrigerator.				were identified. The following		
	· ·	a portable air conditioning			were moved to not be plugged		
	unit.				with a power strips or power s	trips	
	1	Office - a dorm style			were removed. the Medical		
	refrigerator.				Records Office - a dorm style		
	l '	ood Managers Office - a dorm			refrigerator.		
	style refrigerator an	d coffee machine.			B) In Room 200 - a portable a	air	
					conditioning unit.		
		knowledged by the Director of			C) In the ADON Office - a don	m	
		time of discovery and	style refrigerator.				
		in at the exit conference with			D) In the Birchwood Managers		
	the Executive Direc				Office - a dorm style refrigerat		
	Maintenance preser	at at 5:00 p.m.			and coffee machine. The power		
		ar a compa			strip in in the Clean Utility area		
		ation and interview, the facility			Cedar Hall a power strip was I	peing	
		tible cords were installed			used to power equipment has		
		n a safe manor. NFPA 99,			been secured. The work light	tnat	
		tes adapters and extension			was being powered by an		
	_	equirements of 10.2.4.2.1			extension cord was removed.		
	_	shall be permitted. Section			10/10-04	.	
		cabling shall comply with			What measures will be put in	ITO	
		2.3.5.1 states cord strain relief			place and what systemic		
		the attachment of the power			changes will be made to		
		e so that mechanical stress,			ensure that the deficient	.	
	_	bend, is not transmitted to			practice does not recur: A full		
	affect 4 staff.	s. This deficient practice could			audit of the facility found that r	IO	
	aneci 4 stan.				other deficient practices were	_	
	Findings in aluda				present. All staff were inservio		
	Findings include:				on power strips and extension		
	Dagad on -1	and and intermitary desires			cords.		
		ons and interview during a			Harriston and the second		
	tour of the facility v				How the corrective action wi	"	
	Iviaintenance on 08/	04/22 between 1:00 p.m. and			be monitored to	l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/04/2022					
	PROVIDER OR SUPPLIER		300 W	STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR 4:30 p.m., in the Clo	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ean Utility area on Cedar Hall a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)  ensure the deficient praction	DATE  COMPLETION  DATE			
	and was not secured condition could put causing damage to t	ng used to power equipment d, dangling from the wall. This stress on the power cord the power cord. Based on e of observations, the Director		will not recur, i.e., what qu assurance program will be into place:  The maintenance director a	put			
	dangling, not secure will need to be mou	eed the power strip was ed, and stated the power strip anted or set on the floor.		his designee will authorize used for the strips and report to committee weekly for 4 week monthly for 6 months and not administrator of findings	o safety ks and			
	Maintenance at the			ed to ted in ught to				
	failed to ensure flex substitute for fixed state unless specific cords and cables sha substitute for fixed	ation and interview, the facility tible cords were not used as a wiring. NFPA-70/2011, 400.8 cally permitted in 400.7 flexible all not be used for (1) as a wiring. This deficient practice staff in the maintenance attic						
	tour of the facility w Maintenance on 08/ 4:30 p.m., in the ma light was being pow Other extension cor near the work light. of observation, the lacknowledged an ex-	ons and interview during a with the Director of 104/22 between 1:00 p.m. and aintenance of the attic, a work wered by an extension cord. ds were laying on the ground Based on interview at the time Director of Maintenance stension cord was in use as d that he was unaware that it						
	This finding was ac	knowledged by the Director of						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	١G	01	COMPLETED	
		155243	B. WING			08/04/2022	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION					DATE
	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)						

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