		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155247	A. BU B. WI	ILDING NG		_ COMPLETED 11/06/2024	
		100241	<i>B.</i> W1		ADDRESS, CITY, STATE, ZIP COD	11/00	- LVLT
	ROVIDER OR SUPPLIER		8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY	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 APPROPRI	ATE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/06/24 Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060 At this Emergency Preparedness survey, Majestic Care of Southport was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 140 certified beds. At the time of the survey, the census was 84.		E 00	E 0000			
	Quality Review con	npleted on 11/12/24					
K 0000							
Bldg. 01	g. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/06/24 Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060 At this Life Safety Code survey, Majestic Care of Southport was found not in compliance with		K 00	000			

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

TITLE (X6) DATE

Broc Bennett Executive Director 11/25/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		(X2) MULTIPLE CO A. BUILDING B. WING					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	Life Safety from Fin National Fire Protect Life Safety Code (L Bldg 01, was survey Health Care Occupation This one story facility Protection of the corridor. The facility has a find detection in the corridor. The facility has a carensus of 84 at the the All areas where residence were sprinklered. The wooden storage she sprinklered.	the tensor of the extra the 2012 edition of the extra Association (NFPA) 101, and the 2012 edition of the extra Association (NFPA) 101, and the original building, and with Chapter 19 Existing ancies. The tensor of the extra the tensor of the extra the ext					
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other						
. <u>.</u> .	interview; the facili documentation for to famoke detectors sleeping rooms was Section 4.6.12.3 states obvious to the publishall be maintained and Signaling Code Maintenance and Tequipment shall be accordance with the	riew, observation and ty failed to ensure he preventative maintenance installed in all resident complete. NFPA 101 in tes existing life safety features c, if not required by the Code, NFPA 72, National Fire Alarm , 2010 Edition, 29.10 ests states fire-warning maintained and tested in manufacturer's published the requirements of Chapter	K 0300	K-0300 VIOLATIONS What corrective actions will be accomplished for those resider found to have been affected by alleged deficient practice? - Monthly inspection now complete and continue to keep updated moving forward. How other residents having the potential to be affected by the	nts / the		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155247	B. W	ING		11/06/	/2024
		l		CTPEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹					
MAILST	IC CARE OF SOUT	THPOPT		8549 S MADISON AVE INDIANAPOLIS, IN 46227			
IVIAJEOI	IC CARE OF SOUT	TIFORI		INDIAN	MAFOLIO, IN 40221		
(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 OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	14. NFPA 72, 14.2.1.1.1 Inspection, testing, and				same deficient		
	maintenance programs shall satisfy the				practice will be identified and	what	
	requirements of this	s Code and conform to the			corrective action will be taken	?	
		cturer's published instructions.					
	This deficient pract	rice could affect all residents,			- All residents have the potent	tial to	
	staff and visitors.				be affected by the deficient		
					practice		
	Findings include:						
					What measures will be put in		
	Based on review of "Battery-Operated Smoke				place or what systemic chang	es	
	Detector Maintenar	nce Log for 2023" and			the facility will make to ensure	9	
	"Battery-Operated Smoke Detector Maintenance				that the deficient practice doe	s not	
	Log for 2024" with the Maintenance Director				recur;		
	during record revie	w from 9:05 a.m. to 12:20 p.m.					
		ost recent battery operated			- Maintenance director comp	leted	
		aning was documented as more			audit on 11/22/2024, and mov	/ing	
	I	The most recent battery			forward November will be		
	_	ector cleaning documentation			dedicated to battery operated		
		January 2023. The			smoke detector cleaning.		
		Smoke Detector Maintenance			Completed on 11/22/2024.		
	_	not document any battery					
	_	ector cleaning for calendar			How the corrective action(s) v	vill be	
	1 *	on interview at the time of			monitored to ensure the defici	ient	
		Maintenance Director stated he			practice will not recur?		
	_	cords in Direct Supply TELS			The Maintenance Director or		
	_	tation but agreed additional			designee will audit the		
		oom smoke detector battery			battery-operated smoke detec	ctor	
	_	locumentation for the most			cleaning maintenance log for		
		h period was not available for			23/2024 quarterly to ensure the	ney	
		review of Direct Supply TELS			are in place and properly		
	•	tation in the Maintenance			functioning monthly for prever	ntive	
	_	r of the facility from 12:45 p.m.			maintenance. The results of		
	_	06/24, no battery operated			audits will be reviewed in QAF	PI for	
		aning task was in the computer			6 months or until 100%		
		no resident sleeping room			compliance has been maintai		
		tery operated cleaning			The facility, through their QAF		
		the most recent twelve month			program, will review, update,		
		e for review. Based on			make changes as needed for		
		he Maintenance Director			sustaining substantial complia	ance	
	during the tour of the facility, all resident sleeping				for no less than 6 months.		

CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155247	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/06/2024		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(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		
	battery operated an detector. Manufact to the Kidde Model on the ceiling in restated to "clean the	ors in Bldg 01 and Bldg 02 are d are the same model smoke curer's documentation affixed i9040 smoke detector installed sident sleeping Room 168 detector annually".		What date the systemic chang will be completed? 11/22/202			
	during the exit conf	the Maintenance Director Ference.					
K 0321 SS=E Bldg. 01	3.1-19(b) NFPA 101 Hazardous Areas	- Enclosure					
Diag. 01	failed to ensure 1 o as combustible stor square feet) were so smoke resistant par be self closing or a with 7.2.1.8. This o over 20 residents, s	on and interview, the facility f over 20 hazardous areas such age rooms/spaces (over 50 eparated from other spaces by titions and doors. Doors shall atomatic closing in accordance deficient practice could affect taff and visitors in the vicinity orage Room by the main dining	K 0321	K-0321 What corrective actions will be accomplished for those reside found to have been affected be deficient practice; All staff in serviced on not placing tape/object in the door plate to prevent the door from closing entirely.	ents Py		
	Director during a to p.m. to 3:05 p.m. o the door frame for the Ancillary Storage I was taped over while latch into the door in multiple times. The over 50 square feet	ons with the Maintenance our of the facility from 12:45 in 11/06/24, the latching plate on the corridor door to the Room by the main dining room on the did not allow the door to frame when tested to close a Ancillary Storage Room was in size and was used to store set throughout the room. The		How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken; All residents have the potent be affected by this deficient practice. What measures will be put in	to ient action		

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door was equipped with a self closing device.

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place or what systemic changes

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155247 11/06/2024

155247		B. WING		11/06/2024	
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP COD		
			S MADISON AVE		
MAJESI	TIC CARE OF SOUTHPORT	INDIA	ANAPOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Based on interview at the time of the		the facility will make to ensure		
	observations, the Maintenance Director agreed		that the deficient practice does n	ot	
	taping over the latching plate on the door frame		recur;		
	did not separate the storage room from other				
	spaces by smoke resistant partitions and doors		· All Staff in serviced on		
	and removed the tape from the door frame which then allowed the door to self close and latch into		11/19/2024 on not placing		
	the door frame when tested to close.		objects/tape in the door plate		
	the door frame when tested to close.		preventing the door from closing	•	
	These findings were reviewed with the		How the corrective action(s) will	be	
	Administrator and the Maintenance Director		monitored to ensure the deficien		
	during the exit conference.		practice will not recur?		
			i i		
	3.1-19(b)		· The Director of Maintenance or		
			designee to audit the ancillary		
			storage room 3 times a week for	4	
			weeks of zero negative findings		
			achieved. Thereafter, 3 times a		
			month for six months of zero		
			negative findings. After that		
			random monitoring will occur		
			ongoing. The results of audits w		
			be reviewed in QAPI for 6 month	S	
			or until 100% compliance has		
			been maintained. The facility		
			through their QAPI program, will		
			review, update, and make chang	es	
			as needed for sustaining substantial compliance for no les		
			than 6 months.	05	
			tian o montils.		
			What date the systemic changes		
			will be completed? 11/22/2024		
0324	NEPA 101				
S=E	Cooking Facilities				
dg. 01					
-	Based on observation and interview, the facility	K 0324	K-0324	11/29/2024	
	failed to ensure staff had access to a shutoff	3 .	What corrective actions will be	1 27.27.202	

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switch on a timer for 1 of 1 cook tops in the

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accomplished for those residents

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	T 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		
		155247	B. W	B. WING			11/06/2024	
				_	_			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
			8549 S MADISON AVE					
MAJESTI	IC CARE OF SOUT	HPORT		INDIANAPOLIS, IN 46227				
(V4) ID	CUMMADV	CTATEMENT OF DEFICIENCIE		ID	I		(Y5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		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		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		SC 19.3.2.5.4 states within a			found to have been affected by	y		
	_	t, residential or commercial			deficient practice.			
	cooking equipment	that is used to prepare meals			· After Survey exited facility			
	for 30 or fewer pers	ons shall be permitted,			maintenance immediately calle	ed		
	provided that the co	oking facility complies with all			electrician to have them install	а		
	of the following cor	nditions:			timer on the therapy oven, and			
	_	ining the cooking equipment			activity oven. Both the activity			
	is not a sleeping roo				oven and therapy oven have b	een		
		ining the cooking equipment			permanently turned off until the			
		rom the corridor by partitions			timer has been installed.	_		
	_				How the facility will identify oth	er		
	complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10)				residents having the potential			
	and (13) are met.				be affected by the same defici			
	` ′	A switch meeting all of the			<u> </u>			
		-			practice and what corrective a	Clion		
	following is provide				will be taken;			
	1 1	, or a switch located in a			· All residents have the potent	iai to		
		s provided within the cooking			be affected by this deficient			
	-	ates the cooktop or range.			practice.			
		ed to deactivate the cooktop			What measures will be put in			
	_	the kitchen is not under staff			place or what systemic change			
	supervision.				the facility will make to ensure			
		a timer, not exceeding a			that the deficient practice does	not		
	120-minute capacity	y, that automatically			recur;			
	deactivates the cook	ctop or range, independent of			Maintenance Director placed of	all		
	staff action.				to electrician to have them ins	tall		
	This deficient practi	ice could affect over 10			timer on activity/therapy oven	with		
	-	visitors in the vicinity of the			a capacity of 120-minutes. Bot			
	Activities Room.	•			ovens have been taken out of			
					service until timer is installed.			
	Findings include:				The maintenance director or			
					designee will audit the facility			
	Based on observation	ons with the Maintenance			ovens to ensure they are in			
		our of the facility from 12:45			accordance with LSC 19.3.2.5	1		
					The results of audits will be	.4.		
		11/06/24, there was an electric						
	•	vities Room that was			reviewed in QAPI for 6 months			
	-	corridor which had a switch			until 100% compliance has be			
		ed location that deactivates the			maintained. The facility, throug			
	_	he kitchen is not under staff			their QAPI program, will review			
	supervision. No sw	ritch on a timer, not exceeding			update, and make changes as	i		

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120-minute capacity, that automatically

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needed for sustaining substantial

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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	
		155247	B. WING 11/06/2024			2024		
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	₹						
MAJEST	IC CARE OF SOUT	-HDORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227					
MAJEST	CARL OF SOUT			INDIAN				
(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 APPROPRIATE DEFICIENCY)		\TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ktop or range, independent of			compliance for no less than 6			
		e located. Based on interview			months.			
		oservations, the Maintenance			What date the systemic chang	jes		
		electrical shutoff for the			will be completed? 11/29/2024	4		
	cooktop was not on	a timer.						
	These findings were	e reviewed with the						
		he Maintenance Director						
	during the exit conf							
	3.1-19(b)							
K 0353	NFPA 101							
SS=E	_	- Maintenance and Testing						
Bldg. 01	oprimition byotom	Wallice and Feeling						
	Based on observation	on and interview, the facility	K 0	353	K-0353		11/29/2024	
		f over 100 sprinkler heads in	IK 0	333	What corrective actions will be	۾	11/2//2024	
		vere painted or were not in the			accomplished for those reside			
	-	vere replaced in accordance			found to have been affected b			
		PA 25, Standard for the			deficient practice;	,		
		, and Maintenance of			After the survey exited, contra	actor		
		Protection Systems, 2011			was contacted to repair the			
		2.1.1.1 states sprinklers shall not			sprinkler head that was painte	ed in		
		ge; shall be free of corrosion,		room 135. The sprinkler				
		aint, and physical damage; and		escutcheon and sprinkler in room				
		the correct orientation (e.g.,		149 was fixed by maintenance				
		or sidewall). Furthermore, at			once survey exited the buildin			
		tler that shows signs of any of			Completed on or before	Ĭ		
	the following shall				11/29/2024.			
	(1) Leakage	-			How the facility will identify otl	ner		
	(2) Corrosion				residents having the potential			
	(3) Physical Damag	ge			be affected by the same defic			
		the glass bulb heat responsive			practice and what corrective a			
	element	•			will be taken;			
	(5) Loading				All residents have the potentia	al to		
		painted by the sprinkler			be affected by the practice.			
	manufacturer.	-			What measures will be put in			
	In lieu of replacing	sprinklers that are loaded with			place or what systemic chang	es		
		to clean sprinklers with			the facility will make to ensure			
	-	y a vacuum provided that the			that the deficient practice doe			

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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	01	COMPLETED		
		155247	B. WING 11/06/2024				
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD			
			8549 S MADISON AVE				
MAJESTI	IC CARE OF SOUT	HPORT	INDI	ANAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION equipment does not touch the sprinkler.		TAG	DEFICIENCY)	DATE		
		ates any sprinkler shall be		recur;			
		ne improper orientation.		A facility wide audit started or 11/11/2024 to ensure all sprir			
	_	ice could affect over 10		· 1	KIEI		
	residents, staff and			heads are in compliance with NFPA 25. We will continue to			
	residents, starr and	visitors.		audit monthly.			
	Findings include:			How the corrective action(s) v	vill he		
	1 managa merawa			monitored to ensure the defic			
	Based on observation	ons with the Maintenance		practice will not recur?			
	Director during a to	ur of the facility from 12:45		A sprinkler head audit of the			
	p.m. to 3:05 p.m. on 11/06/24, the deflector for the			community will be completed			
	ceiling mounted sprinkler installed in the			monthly to verify and ensure	all		
	bathroom for resident sleeping Room 135 was			sprinkler heads meet the			
	painted. In addition, the escutcheon and sprinkler			guidelines and requirements.	The		
		room for resident sleeping		results of audits will be review	ed in		
	_	ially pushed into the attic		QAPI for 6 months or until 10)%		
		ng the attic. Based on		compliance has been maintai			
		e of the observations, the		The facility through their QAP			
		or agreed the aforementioned		program, will review, update,			
	_	were either painted or		make changes as needed for			
	incorrectly oriented	•		sustaining substantial complia	ince		
	These findings were	e reviewed with the		for no less than 6 months. What date the systemic change.	nos.		
		he Maintenance Director		will be completed? 11/29/202			
	during the exit conf			wiii be completed: 11/23/2021	T		
	daring the exit com	erenee.					
	3.1-19(b)						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01							
-	Based on observation	on and interview, the facility	K 0363	K-0363	11/22/2024		
	failed to ensure 1 of	f over 40 corridor doors to		What corrective actions will be			
		oms had no impediment to		accomplished for those reside	ents		
		g into the door frame and		found to have been affected b	y		
	-	sage of smoke. This deficient		deficient practice;			
	_	t over 10 residents, staff and		-During survey room 118, and			
		ty of resident sleeping Room		had a trash can propping the			
	118.			open. Maintenance removed	ihe		
				trash can once he noticed.			

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RY1N21 Facility ID: 000151

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTI		f '		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED		
		155247	B. W	ING		11/06	/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	1		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45				How the facility will identify oth residents having the potential be affected by the same deficience and what corrective a	to ient		
	p.m. to 3:05 p.m. or	11/06/24, the corridor door to			will be taken;			
	resident sleeping Ro	oom 118 was propped in the			-All residents have the potenti	al to		
	fully open position	with a trash can placed on the			be affected by the practice.			
		door. Based on interview at			What measures will be put in			
		rvations, the Maintenance			place or what systemic chang			
	1	aforementioned corridor door			the facility will make to ensure			
		to latching into the door frame			that the deficient practice does	s not		
	and would not resis	t the passage of smoke.			recur;			
	7E1 (* 1'	. 1 .4 4			-Staff in serviced and educate			
	These findings were	he Maintenance Director			never propping a resident roo	m		
				door with a trash can.				
	during the exit conf	erence.		How the corrective action(s) will be monitored to ensure the deficient				
	3.1-19(b)				practice will not recur?	ent		
	3.1-19(0)				-A monthly preventive			
					maintenance audit of the resid	lent		
					room doors will be completed	Jeni.		
					monthly to verify and ensure a	all		
					doors are not propped with	411		
					anything. The results of audits	will		
					be reviewed in QAPI for 6 more			
					or until 100% compliance has			
					been maintained. The facility			
					through their QAPI program, v	vill		
					review, update, and make cha			
					as needed for sustaining	Ü		
					substantial compliance for no	less		
					than 6 months.			
					What date the systemic chang	ges		
					will be completed? 11/22/2024	4		
K 0524	NEDA 404							
K 0521 SS=F	NFPA 101 HVAC							
33-г Bldg. 01	IIVAC							
Diag. 01	1 Based on record	review and interview, the	V A	521	K-0521		11/11/2024	
		sure all smoke dampers in the	KU	JZ1	What corrective actions will be	9	11/11/2024	
1	ı , 	-r	1		I	-	I	

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

Event ID:

RY1N21 Facility ID: 000151

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/06/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227			
(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		
TAG		ted and tested at least every	TAG	accomplished for those resid	DATE	
	year in accordance with NFPA 92A, Standard for			found to have been affected		
	-	tems Utilizing Barriers &		deficient practice;		
		s, 2009 Edition. LSC 9.2.1		-After survey exited maintena		
		ntilating and air conditioning and related equipment shall be		repaired damper #70 in room		
		NFPA 90A, Standard for the		Damper #13 fusible link insta 11/21/2024 and placed in the		
		Conditioning and Ventilating		correct position after survey		
		A, 2012 Edition, Section 5.4.8.2		exited.		
	-	ers shall be maintained in		How the facility will identify of	ther	
	_	FPA 105, Standard for Smoke		residents having the potentia		
	Door Assemblies & Other Opening Protectives.			be affected by the same defic		
	NFPA 105, 2010 Edition, Section 6.5.1 states			practice and what corrective	action	
	smoke dampers for dedicated and non-dedicated			will be taken;		
	-	ems shall be inspected and		-All residents have the potent	tial to	
		e with NFPA 92A, Standard		be affected by the practice.		
		Systems Utilizing Barriers and		What measures will be put in		
		s. NFPA 92A, 2009 Edition,		place or what systemic changes		
		es nondedicated systems shall		the facility will make to ensur		
		nually. This deficient practice		that the deficient practice doe	es not	
	could affect all resid	dents, staff and visitors.		recur;		
	F' 1' ' 1 1			-Maintenance to ensure annu	ıal	
	Findings include:			audits are completed, and reviewed with admin.		
	Based on review of	the smoke damper inspection		How the corrective action(s)	vill be	
		amper Inspection Checklist"		monitored to ensure the defic		
		d 08/10/22 during record		practice will not recur?	NOTE.	
		intenance Director from 9:05		-A preventive maintenance a	udit	
	a.m. to 12:20 p.m. o	on 11/06/24, the facility has a		on the dampers will be comp		
	-	anical smoke dampers located		annually to verify and ensure		
	in the attic. Smoke	damper inspection and testing		dampers are working properl		
	documentation for t	he most recent twelve month		results of audits will be review	•	
	_	lable for review. Based on		QAPI until 100% compliance	• • • • • • • • • • • • • • • • • • •	
		e of record review, the		been maintained. The facility		
		or agreed smoke damper		through their QAPI program,		
	_	ng documentation for the		review, update, and make ch	anges	
		month period was not		as needed for sustaining		
	available for review	7.		substantial compliance for no	less	
				than 6 months.		
	These findings were	e reviewed with the		What date the systemic chan	ges	

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

PRINTED: 12/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/06/2024	
	ROVIDER OR SUPPLIER			8549 S	ADDRESS, CITY, STATE, ZIP COD MADISON AVE APOLIS, IN 46227		
(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)	ΓE	(X5) COMPLETION DATE
	Administrator and to	he Maintenance Director Perence.			will be completed? 11/11/2024		
	3.1-19(b)						
	interview; the facility fire dampers in the necessary maintena 90A. LSC 9.2.1 reair conditioning (H equipment shall be Standard for the Instand Ventilating Systedition, Section 5.4 maintained in according for Fire Doors and NFPA 80, 2010 Eddamper shall be testinstallation. Section inspection frequence 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 instanding deficiencies discover have a space to indicate damper shall not be way. Findings include:	review, observation and ty failed to ensure 2 of over 100 facility were provided nee in accordance with NFPA quires heating, ventilating and VAC) ductwork and related in accordance with NFPA 90A, stallation of Air-Conditioning stems. NFPA 90A, 2012 18.1 states fire dampers shall be redance with NFPA 80, Standard Other Opening Protectives. Ition, Section 19.4.1 states each ted and inspected 1 year after in 19.4.1.1 states the test and by shall then be every 4 years where the frequency is every beer is equipped with a fusible beer removed for testing to ensure k-in-place if so equipped. The blocked from closure in any instant testing shall be tring the location of the fire prection, name of inspector and ered. The documentation shall ficate when and how the corrected. This deficient et all residents, staff and					
	contractor's "Fire D	the fire damper inspection camper Inspection Checklist" d 08/01/24 during record					

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/06/2024	
	PROVIDER OR SUPPLIE		8549 S	ADDRESS, CITY, STATE, ZIP COD S MADISON AVE NAPOLIS, IN 46227	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
K 0753 SS=E Bldg. 01	review with the Maa.m. to 12:20 p.m. identified as #70 ir for the answer to "listed as "Need Regard Repairs Needed". of record review, the was not aware i repaired or replace agreed fire damper documentation on available for review the Maintenance Defacility from 12:45 one fire damper was HVAC ductwork in Business Office new The fire damper di installed and was in The fire damper in sticker to the damper "#13". Bathe observations, the agreed the fire damposition and did not in the fully open por These findings were	re reviewed with the the Maintenance Director ference.	TAG	DEFICIENCY	DATE
	failed to ensure 1 of maintained in acco	on and interview, the facility of over 50 corridor doors were rdance with 19.7.5.6. 19.7.5.6 decorations shall be prohibited	K 0753	K-0753 What corrective actions will be accomplished for those reside found to have been affected by	ents

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		A. BUILDING	01	COMPLETED	
		B. WING		11/06/2024	
		·	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIE	R	8549 \$	S MADISON AVE	
MAJEST	TIC CARE OF SOUT	THPORT	INDIA	NAPOLIS, IN 46227	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
1110	+	occupancy, unless one of the	1110	deficient practice;	5.112
	following criteria is			-During survey combustible	
	_	-retardant or are treated with		decorations were found on th	_
		dant coating that is listed and		physician's office door.	
		tion to the material to which it is		Maintenance immediately rer	noved
	applied.	non to the material to which it is		the combustible decoration.	noved
		s meet the requirements of		How the facility will identify of	her
	1 1	rd Methods of Fire Tests for		residents having the potential	
	· ·	of Textiles and Films.		be affected by the same defic	
		s exhibit a heat release rate not		practice and what corrective a	
		when tested in accordance with		will be taken;	dollori
		rd Method of Fire Test for		-All residents have the potent	rial to
	Individual Fuel Packages, using the 20 kW			be affected by the practice.	idi to
	ignition source.	chages, asing the 20 kV		What measures will be put in	
	_	s, such as photographs,		place or what systemic chang	
	1 1	r art, are attached directly to		the facility will make to ensure	•
		and non-fire-rated doors in		that the deficient practice doe	
	accordance with the			recur;	33 1100
		non-fire-rated doors do not		-Staff in serviced and educate	ed on
		peration or any required		combustible decorations. All	34 311
		r and do not exceed the area		decorations used on doors or	
	limitations of 19.7.			corridor walls will be verified a	
		not exceed 20 percent of the		treated for fire retardancy.	
	* /	loor areas inside any room or		Decorations will not exceed 3	0%
		ompartment that is not		of the door.	-
	-	ut by an approved automatic		How the corrective action(s)	will be
	1 -	accordance with Section 9.7.		monitored to ensure the defic	
		not exceed 30 percent of the		practice will not recur?	
		loor areas inside any room or		-A monthly audit of building d	ecor
	_	ompartment that is protected		will be completed monthly to	
		pproved supervised automatic		all is in accordance. The resu	- I
		accordance with Section 9.7.		audits will be reviewed in QA	
		not exceed 50 percent of the		6 months or until 100%	
		oor areas inside patient		compliance has been maintai	ned.
		ving a capacity not exceeding		The facility through their QAF	
		moke compartment that is		program, will review, update,	
		ut by an approved, supervised		make changes as needed for	
		r system in accordance with		sustaining substantial complia	
	Section 9.7.			for no less than 6 months.	

(5)*They are decorations, such as photographs

What date the systemic changes

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155247	B. WING		11/06/2024	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
MA.IFST	IC CARE OF SOUT	HPORT		S MADISON AVE NAPOLIS, IN 46227		
				10.1. 5215, 114 15221	T	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	
		ch limited quantities that a		will be completed? 11/11/202		
	hazard of fire devel	opment or spread is not				
	present.					
	-	ice could affect over 10				
	Physicians Office.	visitors in the vicinity of the				
	Thysicians Office.					
	Findings include:					
		ons with the Maintenance				
		our of the facility from 12:45				
		1 11/06/24, a large ornamental ffixed to the corridor side of				
		the Physicians Office. The				
		proximately, 40 to 50 percent of				
		dor door. Based on interview				
	at the time of the ob	servations, the Maintenance				
		idn't know if the wreath was				
	· ·	reath was not treated with fire				
		nd agreed the affixed wreath				
	door to the Physicia	t of the face of the corridor				
	door to the r hysicia	ins Office.				
	These findings were					
		he Maintenance Director				
	during the exit conf	erence.				
	3.1-19(b)					
K 0914	NFPA 101					
SS=E		s - Maintenance and				
Bldg. 01	Testing					
		view, observation and	K 0914	K-0914	11/25/2024	
	interview; the facili	•]		
		electrical receptacles that failed		What corrective actions will be	- I	
	_	of over 50 resident rooms were tal-grade receptacles. NFPA		accomplished for those reside found to have been affected by		
	-	ectrical Code, 2011 Edition, at		deficient practice;	y e	
		tates each patient bed location		aonoioni praodioo,		
		ith a minimum of four		-During survey it was observ	ed	

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STATEMENT OF DEFICIENCIES X1) P.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
155247		B. WING 11/06/2024			/2024		
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			MADISON AVE		
MA IEST	IC CARE OF SOUT	HPORT			IAPOLIS, IN 46227		
IVIAULUI				וואטואוו	TOLIO, IIV TOZZI		
(X4) ID		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		hall be permitted to be of the			that room 103, 125, and 152 h		
		uadruplex type, or any			failed receptacle testing and h		
		three. All receptacles, whether			yet to be replaced. Maintenan		
		be listed "hospital grade" and			replaced all defected receptad	les	
		not intended that there be a			and outlet boxes with hospital	00.4	
		placement of existing receptacles. It is intended,			grade receptacles on 11/25/20	J ∠ 4.	
		receptacies. It is intended,			How the facility will identify at	or	
		tal grade receptacles upon			How the facility will identify oth		
		, renovation, or as existing			residents having the potential be affected by the same defici		
		placement. This deficient			practice and what corrective a		
	practice could affect				will be taken;	Clion	
	practice could affect over 3 residents.				will be taken,		
	Findings include:				-All residents have the potent	ial to	
	Thidings metade.			be affected by the practice.			
	Based on review of	"Receptacle Testing"			, '		
	documentation date	d 10/03/24 and 10/04/24 with			What measures will be put in		
	the Maintenance Di	rector during record review	place or what systemic changes				
	from 9:05 a.m. to 12	2:20 p.m. on 11/06/24, select			the facility will make to ensure		
	electrical receptacle	es in outlet boxes in three			that the deficient practice does	s not	
	resident sleeping ro	oms failed annual inspection			recur;		
	and testing. Each o	f the receptacles which failed	-Maintenance to conduct annual				
	_	nd testing were listed as	receptacle testing. If receptacle				
	_	ntion Force > 4 ounces". The			fails then the receptacle will be		
	October 2024 inspe	_			replaced immediately with hos	pital	
		ed "Replace ASAP" as the			grade receptacle.		
	1 *	-Corrective Action". The			l		
	_	tlet boxes in resident sleeping			How the corrective action(s) w		
		the October 2024 testing as			monitored to ensure the defici	ent	
	failing were located				practice will not recur?		
	a. Room 103, outlet				-A monthly preventive		
	b. Room 103, outlet				maintenance audit of the		
	c. Room 125, outlet				receptacles will be completed	.II	
	d. Room 152, outlet	at the time of record review,			monthly to verify and ensure a	Ш	
					work properly. The results of	l for	
		rector stated the receptacles			audits will be reviewed in QAF	1 101	
	1	have not yet been replaced. ons with the Maintenance			6 months or until 100%	and .	
					compliance has been maintair		
	I -	our of the facility from 12:45	1		The facility through their QAPI		
	p.m. to 3:03 p.m. of	n 11/06/24, outlet box #2 in	1		program, will review, update, a	and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/06/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTHPORT		STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		oom 125 and outlet box #1 in com 152 did not have otacles.			make changes as needed for sustaining substantial complia for no less than 6 months.	ince	
	These findings were Administrator and t during the exit conf	he Maintenance Director			What date the systemic chang will be completed? 11/25/202		
K 0918 SS=F	3.1-19(b) NFPA 101 Floatrical Systems	Esceptial Electric Syste					
SS=F Bldg. 01	Electrical Systems - Essential Electric Syste		K 09	K 0918 K-0918 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; -During survey it was noted that battery powered emergency lighting was not in the vicinity of the outside generator. Maintenance will install a battery powered lighting system near the generator. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; -All residents have the potential to be affected by the practice. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not		ents y at of ery the ner to ient iction al to	11/22/2024
	p.m. to 3:05 p.m. or diesel fuel fired emo	ur of the facility from 12:45 in 11/06/24, the facility has one ergency generator located in a fenced enclosure on the			recur; -Maintenance installed battery powered flood light near gene		

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ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/06/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTHPORT			8549 S	ADDRESS, CITY, STATE, ZIP COD MADISON AVE JAPOLIS, IN 46227			
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
	lighting system wa fenced enclosure for interview at the tim Maintenance Direct lighting system wa fenced enclosure for These findings were	re reviewed with the the Maintenance Director	A battery operated stalled inside the enerator. Based on e observations, the eed a battery operated stalled inside the enerator. The property is talled inside the enerator is talled inside the enerator. The property is talled inside the enerator is talled inside the enerator. The property is talled inside the enerator is talled ins		ent udit erify will ths ill nges ess		
K 0920 SS=E Bldg. 01	Extens Based on observatifailed to ensure mucords including possibilitate for fixed utilities to comply requires electrically with NFPA 70, Na Edition. NFPA 70 unless specifically cables shall not be wiring of a structure building service equivalent for life safety shall approved in according standards. NFPA 9 Facilities, 2012 edias any portion of a	nent - Power Cords and on and interview, the facility altiplug adaptors and extension wer strips were not used as a wiring. LSC 19.5.1 requires with Section 9.1. LSC 9.1.2 wiring and equipment to comply tional Electrical Code, 2011 , Article 400.8 requires that, permitted, flexible cords and used as a substitute for fixed re. LSC Section 4.5.7 states any juipment or safeguard provided be designed, installed and lance with all applicable NFPA 199, Standard for Health Care sition, defines patient care areas health care facility wherein ed to be examined or treated.	K 0	920	K920 What corrective actions will be accomplished for those residen found to have been affected by deficient practice; -After survey exited all noted power strips were removed fror service, and building audited for additional power strips. How the facility will identify other residents having the potential to be affected by the same deficie practice and what corrective act will be taken;	m or er o ent	11/25/2024

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Patient care vicinity is defined as a space, within a

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-All residents have the potential to

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EPARTMENT	T OF HEALTH AND HUN	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	R MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155247	B. WING			11/06/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTHPORT			STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
·	location intended fo	r the examination and			be affected by the practice.		
		11 (0 (1 0)	I				

treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors.

Findings include:

Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:05 p.m. on 11/06/24, the following was

a. a cell phone charging cable was plugged into a power strip placed on the floor next to the bed nearest the corridor door in resident sleeping Room 107. The UL listing of the power strip was 1363A. In addition, three cell phone charging cables were plugged into a power strip placed on the floor next to the window in Room 107. The UL listing of the power strip could not be determined. b. a television and a refrigerator were plugged into a multiplug adaptor in resident sleeping Room 150. c. a television and two cell phone charging cables were plugged into a power strip placed on the floor two feet from the resident bed nearest the corridor door in resident sleeping Room 144. The UL listing of the power strip could not be determined.

Based on interview at the time of the observations, the Maintenance Director agreed power strips were being used in the patient care vicinity for non-PCREE and multiplug adaptors

What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

-A facility wide audit completed on 11/25/2024 to ensure all power strips were removed from the facility. Monthly audits will be completed until in 100% compliance.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur?

-A monthly preventive maintenance audit of the community will be completed monthly to verify and ensure all power strips in use meet the guidelines and requirements. The results of audits will be reviewed in QAPI for 6 months or until 100% compliance has been maintained. The facility through their QAPI program, will review, update, and make changes as needed for sustaining substantial compliance for no less than 6 months.

What date the systemic changes will be completed? 11/25/2024

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
155247		B. WING		11/06/2024		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF SOUT	THPORT		MADISON AVE IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	, i	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		
TAG	+	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	ed as a substitute for fixed				
		mentioned three resident				
	sleeping rooms.					
	These findings wer	e reviewed with the				
	1	the Maintenance Director				
	during the exit conf	ference.				
	3.1-19(b)					
K 0000						
Bldg. 02						
· ·	A Life Safety Code	Recertification and State	K 0000			
	Licensure Survey w	vas conducted by the Indiana				
	Department of Hea	lth in accordance with 42 CFR				
	483.90(a).					
	Survey Date: 11/00	6/24				
	Facility Number: 0	000151				
	Provider Number:					
	AIM Number: 100	284060				
	And Tie Great					
	1	Code survey, Majestic Care of and not in compliance with				
	Requirements for P	_				
		l, 42 CFR Subpart 483.90(a),				
		re and the 2012 edition of the				
	-	ction Association (NFPA) 101,				
		LSC). The 2007 addition, Bldg				
		vith Chapter 19 Existing Health				
	Care Occupancies.	-				
	The 2007 addition t	to this one story facility was				
		Type V (111) construction and				
		The facility has a fire alarm				
		detection in the corridors and				
	1 7	the corridor. The facility has				

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battery operated smoke detectors in all resident

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/06/2024			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTHPORT			STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(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)	(X5) COMPLETION DATE		
K 0324 SS=E Bldg. 02	sleeping rooms. The and had a census of All areas where rest were sprinklered. The wooden storage she sprinklered. NFPA 101 Cooking Facilities Based on observation failed to ensure staff switch on a timer for Therapy Room. LS smoke compartment cooking equipment for 30 or fewer persprovided that the coof the following conform (2) The space contains is not a sleeping roof (2) The space contains all be separated from form the space contains and (13) are met. 19.3.2.5.3(9) states following is provided and locked switch restricted location, facility that deactive (b) The switch is used or range whenever supervision. (c) The switch is on the switch	re facility has a capacity of 140 at the time of this visit. The facility has two detached and which were each not the facility for 1 of 1 cook tops in the facility of 1 cooking acility compressions shall be permitted, sooking facility complies with all inditions: ining the cooking equipment from the corridor by partitions 3.6.2 through 19.3.6.5. Its of 19.3.2.5.3(1) through (10) A switch meeting all of the	K 0324	K-0324 What corrective actions will be accomplished for those reside found to have been affected by deficient practice. After Survey exited facility maintenance immediately calle electrician to have them install timer on the therapy oven, and activity oven. Both the activity oven and therapy oven have be permanently turned off until the timer has been installed. How the facility will identify oth residents having the potential be affected by the same deficipractice and what corrective awill be taken; All residents have the potential be affected by this deficient practice. What measures will be put in place or what systemic change the facility will make to ensure that the deficient practice does recur;	ants y ed la d la deen e ner to ent ction ital to		
	deactivates the cool staff action.	ctop or range, independent of		Maintenance Director placed of to electrician to have them inst			

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This deficient practice could affect over 5

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timer on activity/therapy oven with

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155247		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/06/2024			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTHPORT		8549 \$	STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	residents, staff and residents in the staff superior and switch located deactivates the cook not under staff superior cooktop was located cooktop but the cab switch on a timer, in capacity, that autom cooktop or range, in could be located. But of the observations, agreed the switch for unlocked cabinet ab was not on a timer.	he Maintenance Director	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) a capacity of 120-minutes. Bot ovens have been taken out of service until timer is installed. The maintenance director or designee will audit the facility ovens to ensure they are in accordance with LSC 19.3.2.5. The results of audits will be reviewed in QAPI for 6 months until 100% compliance has be maintained. The facility, through their QAPI program, will review update, and make changes as needed for sustaining substan compliance for no less than 6 months. What date the systemic chang will be completed? 11/29/2024	.44 or een gh v, tial es		
Bldg. 02	Based on observation failed to ensure 1 of sleeping rooms in the impediment to closiframe and would retained. This deficient practice.	on and interview, the facility f 15 corridor doors to resident ne 2007 addition had no ng and latching into the door sist the passage of smoke. ice could affect over 10 visitors in the vicinity of	K 0363	K-0363 What corrective actions will be accomplished for those reside found to have been affected by deficient practice; -During survey room 118, and had a trash can propping the copen. Maintenance removed the	nts y 162 loor		

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

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/06/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF SOUTHPORT			STREET ADDRESS, CITY, STATE, ZIP COD 8549 S MADISON AVE INDIANAPOLIS, IN 46227				
(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		
IAU	Based on observation Director during a to p.m. to 3:05 p.m. or resident sleeping R fully open position floor up against the the time of the observation of the observation of the control of the control of the control of the control of the passage of the series of the passage of the control o	ons with the Maintenance our of the facility from 12:45 in 11/06/24, the corridor door to oom 162 was propped in the with a trash can placed on the door. Based on interview at ervations, the Maintenance dent sleeping rooms 160 to 182 ition and agreed the rridor door had an impediment door frame and would not f smoke.	IAU	trash can once he noticed. How the facility will identify out residents having the potential be affected by the same defice practice and what corrective a will be taken; -All residents have the potential be affected by the practice. What measures will be put in place or what systemic change the facility will make to ensure that the deficient practice does recur; -Staff in serviced and educate never propping a resident rook door with a trash can. How the corrective action(s) we monitored to ensure the deficient practice will not recur? -A monthly preventive maintenance audit of the residence and the residence of the proposed with anything. The results of audits be reviewed in QAPI for 6 moor until 100% compliance has been maintained. The facility through their QAPI program, we review, update, and make chast as needed for sustaining substantial compliance for no than 6 months. What date the systemic change will be completed? 11/23/2022.	her to ient action ial to es es s not ed on m vill be ient dent all s will nths will anges less ges		

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