STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155247	A. BUILDING -- B. WING	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTHPORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 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. Quality Review completed on 11/12/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 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 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Broc Bennett	Executive Director	11/25/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). The original building, Bldg 01, was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 140 and had a census of 84 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached wooden storage sheds which were each not sprinklered. Quality Review completed on 11/12/24			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors installed in all resident sleeping rooms was complete. NFPA 101 in Section 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter	K 0300	K-0300 VIOLATIONS What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? - Monthly inspection now complete and continue to keep it updated moving forward. How other residents having the potential to be affected by the	11/22/2024

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	14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Battery-Operated Smoke Detector Maintenance Log for 2023" and "Battery-Operated Smoke Detector Maintenance Log for 2024" with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 11/06/24, the most recent battery operated smoke detector cleaning was documented as more than one year old. The most recent battery operated smoke detector cleaning documentation was documented as January 2023. The "Battery-Operated Smoke Detector Maintenance Log for 2024" did not document any battery operated smoke detector cleaning for calendar year 2024. Based on interview at the time of record review, the Maintenance Director stated he keeps additional records in Direct Supply TELS computer documentation but agreed additional resident sleeping room smoke detector battery operated cleaning documentation for the most recent twelve month period was not available for review. Based on review of Direct Supply TELS computer documentation in the Maintenance Office during a tour of the facility from 12:45 p.m. to 3:05 p.m. on 11/06/24, no battery operated smoke detector cleaning task was in the computer documentation and no resident sleeping room smoke detector battery operated cleaning documentation for the most recent twelve month period was available for review. Based on observations with the Maintenance Director during the tour of the facility, all resident sleeping		same deficient practice will be identified and what corrective action will be taken? - All residents have the potential to be affected by the deficient practice What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur; - Maintenance director completed audit on 11/22/2024, and moving forward November will be dedicated to battery operated smoke detector cleaning. Completed on 11/22/2024. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director or designee will audit the battery-operated smoke detector cleaning maintenance log for 23/2024 quarterly to ensure they are in place and properly functioning monthly for preventive maintenance. 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.	

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	room smoke detectors in Bldg 01 and Bldg 02 are battery operated and are the same model smoke detector. Manufacturer's documentation affixed to the Kidde Model i9040 smoke detector installed on the ceiling in resident sleeping Room 168 stated to "clean the detector annually". These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		What date the systemic changes will be completed? 11/22/2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 20 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Ancillary Storage Room by the main dining room. 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 latching plate on the door frame for the corridor door to the Ancillary Storage Room by the main dining room was taped over which did not allow the door to latch into the door frame when tested to close multiple times. The Ancillary Storage Room was over 50 square feet in size and was used to store combustible supplies throughout the room. The door was equipped with a self closing device.	K 0321	K-0321 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; · All staff in serviced on not placing tape/object in the door plate to prevent the door from closing entirely. 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 this deficient practice. What measures will be put in place or what systemic changes	11/22/2024

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	Based on interview at the time of the observations, the Maintenance Director agreed taping over the latching plate on the door frame did not separate the storage room from other spaces by smoke resistant partitions and doors and removed the tape from the door frame which then allowed the door to self close and latch into the door frame when tested to close. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		the facility will make to ensure that the deficient practice does not recur; · All Staff in serviced on 11/19/2024 on not placing objects/tape in the door plate preventing the door from closing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? · 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 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? 11/22/2024	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to a shutoff switch on a timer for 1 of 1 cook tops in the	K 0324	K-0324 What corrective actions will be accomplished for those residents	11/29/2024

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	Activities Room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Activities Room. 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, there was an electric cooktop in the Activities Room that was separated from the corridor which had a switch located in a restricted location that deactivates the cooktop whenever the kitchen is not under staff supervision. No switch on a timer, not exceeding 120-minute capacity, that automatically		found to have been affected by deficient practice. · After Survey exited facility maintenance immediately called electrician to have them install a timer on the therapy oven, and activity oven. Both the activity oven and therapy oven have been permanently turned off until the timer has been installed. 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 this deficient practice. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Maintenance Director placed call to electrician to have them install timer on activity/therapy oven with a capacity of 120-minutes. Both 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 19.3.2.5.4. 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	

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	deactivates the cooktop or range, independent of staff action could be located. Based on interview at the time of the observations, the Maintenance Director stated the electrical shutoff for the cooktop was not on a timer. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		compliance for no less than 6 months. What date the systemic changes will be completed? 11/29/2024	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads in the facility which were painted or were not in the proper orientation were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the	K 0353	K-0353 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; After the survey exited, contractor was contacted to repair the sprinkler head that was painted in room 135. The sprinkler escutcheon and sprinkler in room 149 was fixed by maintenance once survey exited the building. Completed on or before 11/29/2024. 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	11/29/2024

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	equipment does not touch the sprinkler. Section 5.2.1.1.4 states any sprinkler shall be replaced that is in the improper orientation. 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 deflector for the ceiling mounted sprinkler installed in the bathroom for resident sleeping Room 135 was painted. In addition, the escutcheon and sprinkler installed in the bathroom for resident sleeping Room 149 was partially pushed into the attic space above exposing the attic. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler locations were either painted or incorrectly oriented. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		recur; A facility wide audit started on 11/11/2024 to ensure all sprinkler heads are in compliance with NFPA 25. We will continue to audit monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A sprinkler head audit of the community will be completed monthly to verify and ensure all sprinkler heads 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? 11/29/2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 40 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 118.	K 0363	K-0363 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; -During survey room 118, and 162 had a trash can propping the door open. Maintenance removed the trash can once he noticed.	11/22/2024

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	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 corridor door to resident sleeping Room 118 was propped in the fully open position with a trash can placed on the floor up against the door. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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 recur; -Staff in serviced and educated on never propping a resident room door with a trash can. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? -A monthly preventive maintenance audit of the resident room doors will be completed monthly to verify and ensure all doors are not propped with anything. 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? 11/22/2024	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC 1. Based on record review and interview, the facility failed to ensure all smoke dampers in the	K 0521	K-0521 What corrective actions will be	11/11/2024

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	facility were inspected and tested at least every year in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers & Pressure Differences, 2009 Edition. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.2 states smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies & Other Opening Protectives. NFPA 105, 2010 Edition, Section 6.5.1 states smoke dampers for dedicated and non-dedicated smoke control systems shall be inspected and tested in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers and Pressure Differences. NFPA 92A, 2009 Edition, Section 8.6.5.1 states nondedicated systems shall be tested at least annually. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the smoke damper inspection contractor's "Fire Damper Inspection Checklist" documentation dated 08/10/22 during record review with the Maintenance Director from 9:05 a.m. to 12:20 p.m. on 11/06/24, the facility has a total of seven mechanical smoke dampers located in the attic. Smoke damper inspection and testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed smoke damper inspection and testing documentation for the most recent twelve month period was not available for review. These findings were reviewed with the		accomplished for those residents found to have been affected by deficient practice; -After survey exited maintenance repaired damper #70 in room 154. Damper #13 fusible link installed 11/21/2024 and placed in the correct position after survey exited. 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 recur; -Maintenance to ensure annual audits are completed, and reviewed with admin. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? -A preventive maintenance audit on the dampers will be completed annually to verify and ensure all dampers are working properly. The results of audits will be reviewed in QAPI 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	

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	Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 2 of over 100 fire dampers in the facility were provided necessary maintenance in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Fire Damper Inspection Checklist" documentation dated 08/01/24 during record		will be completed? 11/11/2024	

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	review with the Maintenance Director from 9:05 a.m. to 12:20 p.m. on 11/06/24, the fire damper identified as #70 in Room 154 was listed as "No" for the answer to "Operates Correctly" and was listed as "Need Replaced" as the answer to "Repairs Needed". Based on interview at the time of record review, the Maintenance Director stated he was not aware if the fire damper had been repaired or replaced on or after 08/01/24 and agreed fire damper repair or replacement documentation on or after 08/01/24 was not available for review. 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, one fire damper was observed installed in ceiling HVAC ductwork in the corridor outside the Business Office near the main entrance lobby. The fire damper did not have a fusible link installed and was in the partially closed position. The fire damper inspection contractor affixed a sticker to the damper location identifying it as damper "#13". Based on interview at the time of the observations, the Maintenance Director agreed the fire damper was not in the fully closed position and did not have a fusible link holding it in the fully open position. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors were maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited	K 0753	K-0753 What corrective actions will be accomplished for those residents found to have been affected by	11/11/2024

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	155247	A. BUILDING 01 B. WING	11/06/2024

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	in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs		deficient practice; -During survey combustible decorations were found on the physician's office door. Maintenance immediately removed the combustible decoration. 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 recur; -Staff in serviced and educated on combustible decorations. All decorations used on doors or corridor walls will be verified and/or treated for fire retardancy. Decorations will not exceed 30% of the door. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? -A monthly audit of building decor will be completed monthly to verify all is in accordance. 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	

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	and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Physicians Office. 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, a large ornamental fabric wreath was affixed to the corridor side of the corridor door to the Physicians Office. The wreath covered, approximately, 40 to 50 percent of the face of the corridor door. Based on interview at the time of the observations, the Maintenance Director stated he didn't know if the wreath was fire retardant, the wreath was not treated with fire retardant material and agreed the affixed wreath exceeded 30 percent of the face of the corridor door to the Physicians Office. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		will be completed? 11/11/2024	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 3 of over 50 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four	K 0914	K-0914 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; -During survey it was observed	11/25/2024

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	receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 5 residents. Findings include: Based on review of "Receptacle Testing" documentation dated 10/03/24 and 10/04/24 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 11/06/24, select electrical receptacles in outlet boxes in three resident sleeping rooms failed annual inspection and testing. Each of the receptacles which failed annual inspection and testing were listed as failing due to "Retention Force > 4 ounces". The October 2024 inspection and testing documentation stated "Replace ASAP" as the response to "If Fail-Corrective Action". The select receptacle outlet boxes in resident sleeping rooms identified in the October 2024 testing as failing were located in: a. Room 103, outlet box #1. b. Room 103, outlet box #6. c. Room 125, outlet box #2. d. Room 152, outlet box #1. Based on interview at the time of record review, the Maintenance Director stated the receptacles which failed testing have not yet been replaced. 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, outlet box #2 in		that room 103, 125, and 152 had failed receptacle testing and had yet to be replaced. Maintenance replaced all defected receptacles and outlet boxes with hospital grade receptacles on 11/25/2024. 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 recur; -Maintenance to conduct annual receptacle testing. If receptacle fails then the receptacle will be replaced immediately with hospital grade receptacle. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? -A monthly preventive maintenance audit of the receptacles will be completed monthly to verify and ensure all work properly. 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	

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	resident sleeping Room 125 and outlet box #1 in resident sleeping Room 152 did not have hospital-grade receptacles. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was in accordance with NFPA 99, 2012 Edition, Health Care Facilities Code Section 6.4.1.1.6.1. Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 7.3.1 states the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. NFPA 110 7.3.2 states the emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. This deficient practice could affect staff and all 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 facility has one diesel fuel fired emergency generator located outside the building in a fenced enclosure on the	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 recur; -Maintenance installed battery powered flood light near generator. Completed 11/22/2024	11/22/2024

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	east side of the property. A battery operated lighting system was not installed inside the fenced enclosure for the generator. Based on interview at the time of the observations, the Maintenance Director agreed a battery operated lighting system was not installed inside the fenced enclosure for the generator. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		How the corrective action(s) will be monitored to ensure the deficient practice /will not recur? -A monthly generator lighting audit will be completed monthly to verify and ensure lighting is working properly. 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? 11/22/2024	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure multiplug adaptors and extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a	K 0920	K920 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; -After survey exited all noted power strips were removed from service, and building audited for additional power strips. 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	11/25/2024

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	location intended for the examination and 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 noted: 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		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 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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	were also being used as a substitute for fixed wiring in the aforementioned three resident sleeping rooms. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0000 Bldg. 02	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 Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). The 2007 addition, Bldg 02, was surveyed with Chapter 19 Existing Health Care Occupancies. The 2007 addition to this one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident	K 0000		

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	sleeping rooms. The facility has a capacity of 140 and had a census of 84 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached wooden storage sheds which were each not sprinklered.			
K 0324 SS=E Bldg. 02	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to a shutoff switch on a timer for 1 of 1 cook tops in the Therapy Room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could affect over 5	K 0324	K-0324 What corrective actions will be accomplished for those residents found to have been affected by deficient practice. · After Survey exited facility maintenance immediately called electrician to have them install a timer on the therapy oven, and activity oven. Both the activity oven and therapy oven have been permanently turned off until the timer has been installed. 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 this deficient practice. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Maintenance Director placed call to electrician to have them install timer on activity/therapy oven with	11/29/2024

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	residents, staff and visitors in the Therapy Room. 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, there was an electric cooktop in the Therapy Room that was separated from the corridor but there was no lockable switch or a switch located in a restricted location that deactivates the cooktop whenever the kitchen is not under staff supervision. A switch for the cooktop was located in a cabinet above the cooktop but the cabinet was not locked. No switch on a timer, not exceeding 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action could be located. Based on interview at the time of the observations, the Maintenance Director agreed the switch for the cooktop was in an unlocked cabinet above the stove and the switch was not on a timer. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		a capacity of 120-minutes. Both 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 19.3.2.5.4. 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? 11/29/2024	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 15 corridor doors to resident sleeping rooms in the 2007 addition had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 162.	K 0363	K-0363 What corrective actions will be accomplished for those residents found to have been affected by deficient practice; -During survey room 118, and 162 had a trash can propping the door open. Maintenance removed the	11/22/2024

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	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 corridor door to resident sleeping Room 162 was propped in the fully open position with a trash can placed on the floor up against the door. Based on interview at the time of the observations, the Maintenance Director stated resident sleeping rooms 160 to 182 are in the 2007 addition and agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		trash can once he noticed. 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 recur; -Staff in serviced and educated on never propping a resident room door with a trash can. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? -A monthly preventive maintenance audit of the resident room doors will be completed monthly to verify and ensure all doors are not propped with anything. 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? 11/22/2024	