STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155358	A. BUILDING -- B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/08/24 Facility Number: 000249 Provider Number: 155358 AIM Number: 100267640 At this Emergency Preparedness survey, Majestic Care of Deming Park was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 86 certified beds. At the time of the survey, the census was 62. Quality Review completed on 07/10/24	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 7/29/24 to the life safety survey completed on 7/8/24. We respectfully request a paper review and will provide any additional information requested.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Clevenger	Executive Director/HFA	08/01/2024

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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	preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated	E 0004	=" " p=" "> =" " p=" "> =" " p=" ">	07/29/2024

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	at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 07/08/24 at 12:30 p.m. with the Maintenance Director present, documentation for an updated emergency preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed that the emergency preparedness plan had not had an annual review and update as of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		=”” p=””> =”” p=””> It is the policy of this facility to review the Emergency Management Plan annually. The corrective action taken for those residents found to be affected by the deficient practice includes; There are no residents identified. How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken: All residents have the potential to be affected but none identified. The Emergency Operations Plan has been updated and placed in the Emergency Management Binder. The Emergency Plan will be reviewed at least annually, and this task will be entered into the TELS PM system for monitoring by the Administrator and Maintenance Director and included in the QAPI process for systems reviews. The Administrator will be responsible for monitoring compliance. 7.29.24	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2)			

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	Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would			

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	affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants.	E 0006	It is the policy of this facility to have a facility/community based risk assessment utilizing an all-hazards approach which is reviewed on an annual basis. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents What: **other residents that have**	07/29/2024

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	Findings include: Based on review of Emergency Preparedness Manual on 07/08/24 at 12:30 p.m. with the Maintenance Director present, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director confirmed that an all hazards risk assessment reviewed withing the last twelve months was not available to review at the time of the survey. This finding were reviewed with the Executive Director and Maintenance Director during the exit conference.		**the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Facility Risk-All Hazard Assessment was completed and has been placed in the Emergency Management Binder The Facility Risk-All Hazard Assessment will be reviewed at least annually, and this task will be entered into the TELs system for monitoring by the Administrator and Maintenance Director and included in the QAPI process for systems reviews. Administrator responsible. Completion Date: 7.29.24	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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

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	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan on 07/08/24 at 12:30 p.m. with the Maintenance Director, documentation for updated policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed that the emergency preparedness plan had not had an annual review and update as of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.	E 0013	It is the policy of this facility to review the Emergency Preparedness policies and procedures on an annual basis. **The corrective action taken for those residents found to be affected by the deficient practice includes** There are no identified residents What: **other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Emergency Policies and Procedures Manual has been reviewed by the QAPI team and a signature sheet added to the Emergency Management Binder The Emergency Management Policies and Procedures will be reviewed annually by the QAPI Committee, and a signature sheet	07/26/2024

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			will be placed in the Emergency Managment Binder once the annual review has been completed. This task will be entered into the TELs PM system for monitoring. Administrator will be responsible to monitor compliance. Compliance Date: 7.29.24	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency	E 0029	It is the policy of this facility have and maintain an Emergency Preparedness Plan Communication Plan. **The corrective action taken for those residents found to be affected by the deficient practice includes** There are no identified residents What: **other residents that have**	07/29/2025

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	Preparedness Plan on 07/08/24 at 12:30 p.m. with the Maintenance Director, documentation for an updated communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months. Based on interview at the time of record review, the Maintenance Director confirmed the entire emergency preparedness program had not been reviewed by the facility within the most recent twelve-month period. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		**the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The Emergency Communication Plan has been reviewed, updated and placed in the Emergency Preparedness Binder. The Emergency Communication plan will be reviewed annually with the Emergency Management Preparedness plan by the QAPI Committee. The Administrator will be responsible for completion. Date: 7.29.24	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness			

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	policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.			

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	*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1)			

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	155358	A. BUILDING -- B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the			

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	following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement,	E 0037	It is the policy of this facility to ensure that all newly hired employees receive training on emergency preparedness and all other employees receive annual training on emergency preparedness. Training	07/29/2024

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	and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 07/08/24 at 12:30 p.m., no documentation of annual Emergency Preparedness (EP) training and no documentation to show staff could demonstrate knowledge of the EP was available for review. Based on an interview at the time of records review, the Maintenance Director and the Executive Director stated that EP training within the last year was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		documentation was on file and will be sent with this POC. **The corrective action taken for those residents found to be affected by the deficient practice includes** There are no identified residents What: **other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. All newly hired employees receive information on Emergency Management Policies and Procedures. All current employees receive annual Emergency Management Training via Relias Training. The Emergency Training of all employees will continue to be monitored for completion by the Administrator and or HR director. Certificate for each employee will be printed upon completion of training. HR will maintain a binder of all completed Training. Administrator Responsible. Completion Date: 7.29.24	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),			

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

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

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	to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]			

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

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

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

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

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

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	requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a	E 0039	p="" xml: paraid="22901326" paraeid="{0076fd85-96e1-4b30-9930-d9e2ebd61114}{12}"> **The corrective action taken for those residents found to be affected by the deficient practice includes there are no identified residents** **What: other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.**	07/29/2024

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	community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Executive Director on 07/08/24 at 12:30 p.m., no documentation of a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise if a community drill is not available was available for review. Also, documentation of an additional annual exercise of choice within the last year was not available for review. Based on an interview with the Executive Director, she stated that Emergency Preparedness exercises had been conducted within the last twelve months, however the documentation was not available for review at the time of the survey. This finding was reviewed with the Executive		**On 10/17/2023 an emergency Drill Exercise was held at Deming Park and the documentation was in the TELS program. ED was unaware that Director did not look in TELS for the documentation at the time of the Life Safety Survey.** **The emergency plan will be reviewed at least annually, and this task will be entered into the TELs PM system for monitoring by the Administrator and Maintenance Director and included in the QAPI process for systems reviews.** **ED held another Emergency Drill on 7/23/2024 discussing Tornado Preparedness. Documentation will be sent with this POC.** **The facility will continue to conduct Emergency Drills including unannounced drills at least twice a year, and document response.** **These drills will be entered into TELS, the Maintenance Director or Administrator will be responsible for monitoring for compliance. Date of Compliance: 7.29.24**	

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	155358	A. BUILDING -- B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director and Maintenance Director during the exit conference.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care			

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	Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.			

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	(iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director on 07/08/24 between 9:45 a.m. and 12:50 p.m., no documentation was available for review to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes since February 2024. Additionally, monthly load testing for the months of July to December 2023 were not available to	E 0041	It is the policy of this facility to monitor the emergency generator on a weekly basis. **The corrective action taken for those residents found to be affected by the deficient practice. There are no identified residents. practice.** **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken**: All residents have the potential to be affected but none were identified. **What measures will be put into place and what systemic**	07/29/2025

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	review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for three weeks, checked for additional documentation for monthly generator tests, and none were available for review at the time of the survey. Based on review of "Emergency Generator - Visual Inspection" documentation with the Maintenance Director during record review from 9:45 a.m. to 12:50 p.m. on 07/08/24, documentation of weekly emergency generator inspections for July through October 2023 were not available for review. Additionally, the generator weekly visual inspections for the first three weeks of June 2024 were not available for review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for three weeks and logged a visual inspection on 06/24/2024, has checked for more weekly generator inspections and confirmed that documentation of weekly emergency generator inspections for the aforementioned time frames were not available for review. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference.		**changes will be made to ensure that the deficient practice does not recur**: The new Maintenance Director was informed of the deficient practice. The Emergency generator will be tested weekly by the Maintenance Director and results recorded. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be conducted monthly with the quality assurance committee to assure that the Emergency Generator is being tested weekly and documentation is completed at the times of testing. Administrator Responsible Compliance Date: 7.29.24**	
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: 07/08/24 Facility Number: 000249	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our	

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	Provider Number: 155358 AIM Number: 100267640 At this Life Safety Code survey, Majestic Care of Deming Park was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the resident sleeping rooms, corridors and in all areas open to the corridor. The facility has a capacity of 86 and had a census of 62 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/10/24		regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 7/29/24 to the life safety survey completed on 7/8/24. We respectfully request a paper review and will provide any additional information requested.	
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to ensure 3 of 3 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided.	K 0291	**It is the policy of this facility to monitor the emergency lighting on a monthly basis.** **The corrective action taken for those residents found to be affected by the deficient practice. There are no**	07/29/2024

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	Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect staff. Findings include: Based on record review on 07/08/24 from 9:45 a.m. to 12:50 p.m. with the Maintenance Director, there was no annual Battery Operated Emergency Light Testing available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has a battery operated emergency light at the generator and in the boiler room, and documentation for annual test within the last twelve months was not available for review. Additionally, 30 second monthly testing for July through November 2023, May and June of 2024 was not available for review. Based on observations during a tour of the facility with the Maintenance Director on 07/08/24 from 12:50 p.m. to 2:50 p.m., the facility has a battery operated emergency light on the exterior wall by the generator and two battery operated emergency lights were located in the boiler room. Based on interview with the Maintenance Director, he stated no monthly testing for the aforementioned timeframes and annual testing was available for review at the time of the survey. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference.		**identified residents. How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken: All residents have the potential to be affected but none were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The new Maintenance Director was informed of the deficient practice. The Battery-Operated Emergency Testing will be performed on monthly basis for 30 seconds and annually for 90 minutes. One of the two emergency light cited as a battery-operated light (near generator) is not battery powered. It is direct wired and operates by a light switch. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be conducted monthly to assure that emergency lighting is being tested weekly and documentation is completed at the time of testing. Documentation of these tests will be reviewed by the quality assurance committee.**	

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	3.1-19(b)		**Executive Director Responsible. Completion: 7.29.24**	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time, date, and year information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 07/08/24 at 1:55 p.m., the facility fire alarm control panel had the incorrect time and date. At 1:55 p.m. on 07/08/24 the fire alarm control panel displayed 02/20/10 and 11:03 p.m. Based on an interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time corrected as soon as he could.	K 0345	**The corrective action taken for those residents found to be affected by the deficient practice.** There are no identified residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: SafeCare came to the facility on July 17, 2024 and reset fire alarm system to display the correct date and time. H**ow other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken**: All residents have the potential to be affected but none were identified.	07/29/2024

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	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: The Maintenance Director will visually inspect the fire panel daily (Monday-Friday) to ensure accurate date and time. Administrator to complete random audits for compliance and record in TEL's PM system. Administrator Responsible. Completion: 7.29.24	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility	K 0351	**The corrective action taken for**	07/29/2024

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	failed to maintain the ceiling construction in Physical Therapy in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and at least 3 residents in Physical Therapy. Findings include: Based on observation with the Maintenance Director on 07/08/24 at 1:35 p.m., the sprinkler in the restroom located in Physical Therapy had an approximate half inch annular space around the sprinkler that exposed the attic. Based on interview at the time of observation, the Maintenance Director confirmed the half inch space around the sprinkler exposed the attic in the Physical Therapy restroom. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**those residents found to be affected by the deficient practice.** There are no identified residents. H**ow other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken**: Three residents have the potential to be affected but were not identified by the surveyor. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: SafeCare will install escuthcheons on the annular space around the sprinkler heads. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: The Maintenance Director will conduct monthly audits, to ensure that annular space around sprinkler heads are present. Administrator Responsible. Completion: 7.29.24	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of documentation for the most recent twelve month period with the Maintenance	K 0353	**The corrective action taken for those residents found to be affected by the deficient practice.** There are no identified residents. **The corrective action taken for those residents found to be affected by the deficient practice. All residents have the potential to be affected.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: New Maintenance Director updated on the status of dry sprinkler testing. Dry sprinkler testing has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: The Maintenance Director will continue to do weekly Dry Sprinkler	07/31/2024

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	Director during record review from 9:45 a.m. to 12:50 p.m. on 07/08/24, weekly dry sprinkler system gauge inspection documentation for July through October 2023 was not available for review. Additionally, dry sprinkler gauge inspections for April through June 2024 were not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 7 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated he has been on the job three weeks and confirmed sprinkler system gauge and control valve inspection documentation for the aforementioned weekly periods was not available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 2. Based on observation, and interview; the facility failed to ensure 1 of 1 sprinkler heads in the walkin freezer with a bent deflector was 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		Inspections of the sprinkler system and document outcomes. ED will conduct random audits to ensure compliance. This task will be entered into the TELs PM system. Safe Care replaced the bent sprinkler deflector Tile in the linen closet ceiling has been replaced. Administrator Responsible. Completion: 7.31.24	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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 equipment does not touch the sprinkler. This deficient practice could affect dietary staff. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 2:47 p.m. on 07/08/24, the sprinkler located in the walk in freezer had a bent and damaged deflector. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler had a bent deflector. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 200 Hall Linen rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 10 residents, staff, and visitors in the vicinity of the linen room on 200 Hall. Findings include:			

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	Based on observation with the Maintenance Director during a tour of the facility at 2:26 p.m. on 07/08/24, a two foot by six foot area of the ceiling tiles were missing in the 200 Hall linen room by resident room 215. These missing ceiling tiles exposed the attic space above. The room was equipped with one pendant sprinkler installed on the ceiling. Based on interview at the time of the observation, the Maintenance Director confirmed the missing ceiling tiles in the linen room. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to conduct fire drills on each shift for 4 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under	K 0712	**It is the policy of this facility to conduct quarterly fire drills on each shift on unexpected days and at unexpected times under varying conditions.** **How other residents that have the potential to be affected by**	07/29/2025

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	varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 07/08/24 at 10:20 a.m., the following was noted: a) no fire drill documentation was available for the first and second shifts for the first quarter of 2024 b) no fire drill documentation was available for the first and second shift for the second quarter of 2024 b) no documentation was available to show a first and third shift fire drill for the third quarter of 2023/2024 c) no documentation was available to show a first and second shift fire drill for the fourth quarter of 2023 Based on an interview at the time of record review, the Maintenance Director stated he had been on the job for three weeks, had searched for fire drill records and that no additional documentation was available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 2. Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.		**the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. A fire drill was conducted on 7/15/2024.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The new Maintenance director was in-service that fire drills must be held every month on staggering dates and times throughout the month. Every quarter a drill must be conducted on each shift. Drills that occur on the night shift with a silent alarm must be reviewed and alarm sounding the following day.** **Transmission of a fire alarm signal and simulation of the emergency fire conditions must occur and will be documented on the fire drill paperwork.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance director and/or his designee will conduct monthly fire drills that are on different shifts and staggered throughout the month, quarter and year. This**	

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	Findings include: Based on record review of titled "Fire Drill Report" with the Maintenance Director on 07/08/24 at 10:15 a.m., the fire drill documented 02/09/24 at 11:30 p.m., had no information documented in the area to indicate transmission of signal. Based on interview at the time of record review, the Maintenance Director stated he had been on the job three weeks and confirmed the 02/09/24 at 11:30 p.m. fire drill did not document the verification of the transmission of alarm. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		**task will be entered into the TELS PM system. The times will also be staggered through a 24-hour period, so they all don't fall at the time on the same shift. Fire drill paperwork will be completed. Documentation of the transmission of the signal and outcome of simulation will be completed. Drills will be brought to the quarterly QA meetings for review and signed by attendees. Administrator responsible. Completion: 7.29.24**	
K 0761 SS=D Bldg. 01	Based on records review and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as	K 0761	**It is the policy of this facility to ensure fire doors are inspected annually, which has been completed with no documented findings or concerns.** **The corrective action taken for those residents found to be affected by the deficient practice includes There are no identified residents:** **How other residents that have the potential to be affected by the same defective practice**	07/29/2024

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	otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect staff. Findings include: Based on records review with the Maintenance		**will be identified and what corrective action will be taken: All residents have the potential to be affected but none were identified.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All fire doors have been inspected and findings documented. All doors will be inspected at lease annually and findings documented. This task will be entered into the TELS PM system.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenace Director will put the completed Fire Door Inspection into TELS. Administrator will review when completed. 7.29.24**	

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	Director on 07/08/24 at 12:10 p.m., no documentation of an annual inspection for the Oxygen Transfilling room fire door assembly was available for review. Based on interview with the Maintenance Director, he stated that he checked all the barrier doors and oxygen room door in the building and marked the task complete on 07/03/24 in the computer based records program. The Maintenance Director stated that an annual itemized listing of required fire doors was not available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or			

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	renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect residents on 200 Hall. Findings include: Based on record review with the Maintenance Director at 12:20 p.m. on 07/08/24, annual receptacle retention documentation was not available for review. Based on an interview at the time of record review, the Maintenance Director stated he had been on the job three weeks and had not had time to complete the testing and that prior year documentation was not available to review. The Maintenance Director stated that	K 0914	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected.** **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenace Director will test all non-hospital grade receptacles on an annual basis and document results. All non-hospital grade outlets have been tested and results documented.** **Administrator will audit to ensure continued compliance. This task will be entered into the TELS PM system.** **Compliance 8.1.24**	08/01/2024

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	resident room on 100 Hall had hospital grade receptacles and that some rooms on 200 Hall had hospital grade receptacles. Based on observations made during a tour of the facility from 12:50 p.m. to 2:50 p.m., the 200 Hall resident rooms had approximately six receptacles with a mixture of hospital grade and non hospital grade, which would require an annual inspection. Based on interview at the time of observations, the Maintenance Director confirmed that resident rooms on 200 Hall had non hospital grade electrical receptacles and he would have to get them tested and documented on an itemized form. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 requires spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabalized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:	K 0918	It is the policy of this facility to have a written record of monthly generator load testing. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The new maintenance director will	07/29/2024

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	Based on records review and interview with the Maintenance Director on 07/08/24 between 9:45 a.m. and 12:50 p.m., no documentation was available for review to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes since February 2024. Additionally, monthly load testing for the months of July to December 2023 were not available to review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for three weeks, had checked for additional documentation for monthly generator tests, and none were available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for all 52 weeks from July 2023 through July 2024. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator - Visual Inspection" documentation with the Maintenance Director during record review from 9:45 a.m. to 12:50 p.m. on 07/08/24, documentation of weekly emergency generator inspections for July through October 2023 were not available for review. Additionally, the generator weekly visual inspections for the first three weeks of June 2024 were not available for review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for three weeks and logged a visual inspection on		complete weekly and monthly testing on the generator. Testing was completed on 7/15/2024 and will be completed weekly going forward. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be conducted monthly by the Maintenance Director and reviewed by the quality assurance committee to assure that the Emergency Generator is being tested weekly and monthly and documentation is completed at the time of testing. Documentation of these tests will be reviewed by the quality assurance committee. Executive Director Responsible. Completion: 7.29.24	

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	06/24/2024, has checked for more weekly generator inspections and confirmed that documentation of weekly emergency generator inspections for the aforementioned time frames were not available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			

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	Based on observation and interview, the facility failed to ensure in 1 of 1 Housekeeping office and Laundry room that flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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. This deficient practice affects staff and at least 15 residents in the 100 Hall smoke compartment. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 07/08/24 from 12:50 p.m. to 2:50 p.m. the following was discovered: a) a cell phone charger was plugged into and powered by a white extention cord in the Housekeeping office b) an extention cord was plugged into a powerstrip in the laundry room c) a six outlet multiplug adapter was plugged into and screwed into an outlet nearest the window in resident room 210 Based on interview at the time of each observation, the Maintenance Director confirmed that the extention cords were in use and removed each of them upon observation. The Maintenance Director stated he would remove the multiplug adapter from the outlet as soon as he could. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference 3.1-19(b)	K 0920	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected by the practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. Education covering unapproved devices such as extension cords, plug in adapters will be included in annual fire safety training for all staff. It is the practice of this facility that no extension cords or plug in adapters are to be used at any time. All extension cords and plug in adapters were removed and staff reminded that no extension cords were not allowed in office areas. Social Services will call any families that bring in extension cords or adapters and inform them of regulation. ED and Maintenance will monitor during monthly room rounds. Administrator Responsible. Completion: 7.29.24	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

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K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect staff in the vicinity of the oxygen storage room in the garage. Findings include: Based on observation on 07/08/24 during the tour of the facility with the Maintenance Director at 1:45 p.m., there were five cardboard boxes filled with respitory therapy supplies was stored within five feet of stationary E type oxygen cylinders in the oxygen storage room. Based on interview at the time of observation, the Maintenance Director confirmed that combustible materials were staked up and stored behind the door of the oxygen room within five feet of stationary oxygen cylinders. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0923	What corrective action will be accomplished for those residents found to have been affected by the practice: No residents were identified to be affected. How other residents having the potential to be affected by the same practice will be identified and what corrective action should be taken: All residents have the potential to be affected. No combustible items will be stored within five feet of oxygen cylinders or other gases. Combustible items have been removed and Central Supply staff informed that as soon as oxygen supplies are delivered, they should be taken to Central Supply room and not stored with Oxygen. This will be monitored during routine rounds by Maintenance Director and recorded on the log posted in the oxygen room. Administrator Responsible. Completion: 7.29.24	07/29/2024