STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155376	A. BUILDING -- B. WING	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

(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: 02/06/23 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170 At this Emergency Preparedness survey, Majestic Care of Sheridan was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 79. Quality Review completed on 02/08/23	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a **Post Survey Desk Review on 2.24.23**	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lauren Kirkwood	HFA, RN	02/23/2023

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	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 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.			

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	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. (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			

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	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 equipment, 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 observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., no emergency battery powered light could be found near the generator. The generator was located on the southside of the facility in the yard not adjacent to a parking lot, street or other paved surface, which depending upon the weather and ground conditions, could make it difficult to shine headlights in an emergency. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.	E 0041	E-41 1. The identified missing emergency battery powered light was added near the generator. 2. No other concerns were identified. 3. The Maintenance Director was educated about the requirement of emergency battery powered light near the generator. Maintenance Director will conduct functional testing monthly (minimum of weeks and a maximum of 5 weeks between test) for no less than 30 seconds and annually for a minimum of 1.5 hours if battery powered. Written records of visual inspections and tests will be kept by Maintenance Director. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023
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).	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or	

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	Survey Date: 02/06/23 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170 At this Life Safety Code survey, Majestic Care of Sheridan was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered detectors in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 79 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 02/08/23		of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a **Post Survey Desk Review on 2.24.23**	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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	18.2.1, 19.2.1, 7.1.10.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge paths that lead through courtyard was readily accessible at all times and 1 of 1 procedures on how to unlock the gate in the exit discharge path was known to all staff. This deficient practice could affect all residents in the facility. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the dining hall had a door marked EXIT which led to the facility smoking area into the fenced courtyard. The discharge exit from the fenced courtyard had a chained padlocked gate before accessing the public way. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 4 over corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the	K 0211	K-211 1. The identified padlock was removed. The isolation cart was replaced with one that had wheels. 2. No other locks found to have concerns. No other carts were found to have concerns. 3. The Maintenance Director was educated on proper lock security of gates by the Executive Director. Maintenance Director will complete monthly rounds during routine fire drills to ensure gate is note locked from outside. All staff were educated that any cart that is in the hallway must be on wheels. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023

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	following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects up to 20 residents. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., near Resident Room #217 a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the cart to be move out of the halls during an emergency. Based on an interview at the time of observations, the Maintenance Director searched for the wheels and stated the PPE cart was not equipped with wheels and would need to be replaced with a PPE cart with wheels. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are			

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

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	installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through all exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents, visitors and staff if needing to exit the facility. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the exit doors from the facility were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. The Executive Director stated that she believed the facility had some type of agreement to be able to not post the codes. The surveyor asked if the facility was a completely "Licensed Memory Care Facility" or if all 79 current residents had the appropriate clinical diagnosis documentation on	K 0222	K-222 1. The required codes were posted 2. No other concerns were identified 3. The Maintenance Director was educated on the requirement of is required door codes posted at exits by the Executive Director. Maintenance Director will complete TELS for Fire drill assessment which will include the checking of door codes. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023

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	file. The Executive Director contacted the CEO to inquire about the facilities status and documentation. No documentation was provided. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 4 of over 5 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents and staff. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the following exit discharge issues were observed: A) The Southeast Facility Exit, marked as a facility exit, had a sidewalk with a 2 inch rise where concrete was cracked and presented a trip hazard. B) The South Facility Exit, marked as a facility	K 0271	K-271 1. The identified exit sidewalks have been quoted for repair (see attached). Will be scheduled as soon as possible. 2. No other concerns were identified. 3.The Maintenance Director was educated on the facility's responsibility for ensuring exit discharges had a level walking surface, free from obstructions, and constructed of hard packed all-weather travel surface. Maintenance Director will complete monthly inspection of exit sidewalks when doing	02/24/2023

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	exit, had broken concrete and was uneven. C) The South Facility Exit, marked as a facility exit, had a blacktop section which extended parallel the length of the building, which was uneven, narrow and cracked not providing the required smooth level surface to the public way. D) The Northwest Facility Exit, marked as a facility exit, had a trip hazard where the sidewalk was uneven where it adjoined the concrete landing. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		monthly fire drills. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 3 staff. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the Infection Control Room. greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, PPE supplies and cardboard boxes. The corridor door to this room was not provided with a self-closing device. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)	K 0321	K-321 1. The identified door had a self-closing device added to it. 2. No other doors were found to have this concern. 3. The Maintenance Director was educated on the requirement of a self-closing devices to be on corridor door to any supply room greater than 50 square feet. Maintenance Director will complete monthly review of all office doors to ensure any that require self-closing devices are in place. 4. This was reviewed upon completion by Executive Director. TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023

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K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy area. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10)	K 0324	K-324 1. The identified stove had an auto shut off placed. 2. No other concerns were identified. 3. The Maintenance Director was educated on the requirement of stoves to you have an auto shut off for when not in shut off function of the identified stove. 4. This will be reviewed by the Executive Director/designee weekly for 4 weeks, monthly for 4 months for the placement and	02/24/2023

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	155376	A. BUILDING 01 B. WING	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 10 residents in the therapy area. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., there was a cooktop range in the therapy area and when asked staff were unable to deactivate the range from the power source. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop range and if a shutoff existed which was linked to the range. The Maintenance director stated he was unsure if the cooktop range had a shutoff. At the time of discovery, the aforementioned range had power and was populated on top of the burners with a tissue box and Christmas decorations. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		function of a shut off on the identified stove. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service			

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	Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 02/06/23 between 10:00 a.m. and 12:45 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the	K 0346	K-346 1. The identified missing information was added to the fire watch policy. 2. No other issues were identified. 3. The Maintenance Director was educated on the requirement of the need to list Gateway in the Fire Watch policy by the Executive Director. The IDT will review this plan annually for accuracy. 4. This will be reviewed by the Executive Director upon completion annually with the Disaster Plan review. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023

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	Maintenance Director and Executive Director present. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person	K 0354	K-354 1. The identified missing information was added to the fire watch policy. 2. No other issues were identified. 3. The Maintenance Director was educated on the requirement of the need to list Gateway in the Fire Watch policy by the Executive Director. The IDT will review this plan annually for accuracy. 4. This will be reviewed by the Executive Director upon completion annually with the	02/24/2023

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	should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 02/06/23 between 10:00 a.m. and 12:45 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		Disaster Plan review. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors would	K 0363	K-363	02/24/2023

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	resist the passage of smoke. This deficient practice could affect 4 residents. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the (1) door to resident room #213 when completely shut and latched into the door frame had a 1-inch gap at the top of the door. And (2) the Supply Room Office had 2 ½ inch holes completely through the door. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 2. Based on observation and interview, the facility failed to ensure all resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the (1) corridor door to the medical records room was propped open with a wooden door stop. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door would not close unless the block was first moved. And (2) the corridor door to Resident Room # 219 failed to close and latch positively into the respective door frame.		1. The identified Resident room door 213 was adjusted for proper fit as well as 219 was adjusted for proper latching. The identified with ½ inch holes (2) filled with fire caulk. The identified wood doorstop was removed. 2. No other concerns were identified. 3. The Maintenance Director was educated on the requirement of smoke tight door function, not using door stops, importance of ensuring no holes in doors, and proper latching by the Executive Director. Maintenance Director will complete monthly review of all resident/office doors for holes, proper latching, proper fitting, and ensuring nothing propping them open. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops	K 0511	K-511 1. The identified 2 plugs were replaced with GFCI plugs. The identified receptacle faceplate was installed. 2. No other plugs were found to have concerns. No other faceplates were found to be missing. 3. The Maintenance Director was educated on the requirement of placement of GFCI plugs and requirement of faceplates on all outlets by the Executive Director. Maintenance Director will complete annual required plug inspection to ensure GFCI plugs and outlet faceplates are placed and functioning. 4. This will be reviewed by the Executive Director upon completion, and TELS will be	02/24/2023

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	(4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and		reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	

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	electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents 2 staff. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the (1) outlet near the sink in the Activities Area and (2) the outlet near the sink in Therapy was not provided with ground fault circuit interruption (GFCI). The Maintenance Director at the time of observation stated he did not believe the receptacles were on a GFCI circuit. When tested by the surveyor, it did not appear the aforementioned outlets were on a GFCI circuit. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 2. Based on observation and interview, the facility failed to ensure electrical outlets were protected according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 3 staff in the housekeeping area. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the South Housekeeping area was missing an outlet cover protecting the electrical outlet not			

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	completely covering the receptacle. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)			
K 0712 SS=C 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 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review of the Tels "Logbook Documentation regarding Fire Drills" and interview with the Maintenance Director and Executive Director on 02/06/23 between 10:00 a.m. and 12:45 p.m., 4 of 4 second shift fire drills were conducted at 3 p.m. These conditions do not allow fire drills to be conducted at unexpected times.	K 0712	K712 1. Required fire drills will be staggered going forward. 2. No other concerns with drills. 3. The Maintenance Director was educated on the requirement of varying times for fire drills by the Executive Director. Maintenance Director will complete TELS for monthly fire drills as assigned. 4. This will be reviewed by the Executive Director/designee upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.	02/24/2023

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	This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		5. 2/24/23	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 5 residents, staff and visitors. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., a portable space heater was in use in the Break Room. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was located in the breakroom and that the appliance was not allowed in the facility. No documentation was available for review to show the heating element temperature of the appliance did not exceed 212 degrees. This finding was acknowledged by the Maintenance Director at the time of discovery and	K 0781	K-781 1. The identified space heater was removed from break room. 2. No other concerns were identified. 3. All staff was educated by Executive Director that space heaters are not to be used in the facility. Maintenance will round weekly for 4 weeks, monthly for 4 months to ensure no space heaters are in building. 4. This will be reviewed by ED/Designee weekly for 4 weeks, monthly for 4 months. This information will be sent to QAPI for tending and completion follow-up. 5. 2/24/23	02/24/2023

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	again at the exit conference with the Maintenance Director and Executive Director present. 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 renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as	K 0914	K914 1. The identified receptacles were tested for proper function. 2. No other receptacles were identified. 3. The Maintenance Director was	02/24/2023

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	155376	A. BUILDING 01 B. WING	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SHERIDAN	803 S HAMILTON ST SHERIDAN, IN 46069

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	hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on records review and interview with the Maintenance Director and Executive Director on 02/06/23 between 10:00 a.m. and 12:45 p.m., the most recent itemized listing of inspection and testing electrical outlet receptacles was dated January 2022 and was older than the required twelve-month testing period. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present.		educated on the requirement of annual receptacle inspections by the Executive Director. Maintenance Director will complete TELS for annual receptacle check using the TELS Receptacle Check Form. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	

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	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 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)			

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	Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights was provided and maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. 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 all residents in the facility. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., no emergency battery powered light could be found near the generator. The generator was located on the southside of the facility in the yard not adjacent to a parking lot, street or other paved surface, which depending upon the weather and ground conditions, could make it difficult to shine headlights in an emergency. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)	K 0918	K-918 1. The identified missing emergency battery powered light was added near the generator. 2. No other concerns were identified. 3. The Maintenance Director was educated about the requirement of emergency battery powered light near the generator. Maintenance Director will conduct functional testing monthly (minimum of weeks and a maximum of 5 weeks between test) for no less than 30 seconds and annually for a minimum of 1.5 hours if battery powered. Written records of visual inspections and tests will be kept by Maintenance Director. 4. This will be reviewed by the Executive Director upon completion, and TELS will be reviewed weekly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023

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K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents. Findings include: Based on observations and interview during a facility tour with the Maintenance Director on 02/06/23 between 12:45 p.m. and 3:00 p.m., the oxygen storage/transfer room did not have a posted sign indicating making a clear distinction between when transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not.	K 0927	K-0927 1. The identified Oxygen in 2. No other concerns were identified. 3. The Maintenance Director was educated by Executive Director that an Oxygen in Use sign should be hung on door of oxygen room. 4. This will be reviewed by the Executive Director/designee weekly for 4 weeks, monthly for 4months for proper Oxygen in Use sign placement. This information will be sent to QAPI for trending and completion follow-up. 5. 2/24/23	02/24/2023

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)			