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	03/13/2023

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 02/6/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/13/23 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170 At this PSR Emergency Preparedness survey, Majestic Care of Sheridan was found 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 PSR survey, the census was 80. Quality Review completed on 03/14/23	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/06/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/13/23 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lauren Kirkwood	HFA, RN	03/27/2023

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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	155376	A. BUILDING 01 B. WING	03/13/2023

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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	At this PSR 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 80 at the time of this PSR visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/14/23			
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 2 of over 5 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel	K 0271	1. The identified exit sidewalks have been quoted for repair, scheduled, and started. 2. No other concerns were	04/23/2023

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	155376	A. BUILDING 01 B. WING	03/13/2023

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	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 03/13/23 between 9:30 a.m. and 10:45 a.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 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. The Maintenance Director stated that a concrete contactor had been selected and that they were waiting for nicer weather. The forecast was to complete the project within the next couple weeks. The facility understood that having an accepted bid would be sufficient and the exit discharge issues would not be recited. This deficiency was cited on 02/06/23. The facility failed to implement a systemic plan of correction to prevent recurrence. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present. 3.1-19(b)		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. The Maintenance Director will complete monthly inspection of exit sidewalks when doing 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. 4/23/23	