PRINTED: 10/05/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION TOTAL SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/31/2023		
	PROVIDER OR SUPPLIER			11W 00E	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 08/31 Facility Number: 0 Provider Number: 100 At this Emergency Care of Lafayette w with Emergency Property Medicare and Medicand Suppliers, 42 Company The facility has 122 the survey, the censure of the survey o	200147 155243 266900 Preparedness survey, Majestic ras found not in compliance reparedness Requirements for caid Participating Providers FR 483.73. Certified beds. At the time of us was 86. 42 CFR, Subpart 483.73 is NOT	E 000	0	Majestic Care of Lafayette submits this POC as our credit allegation of compliance as of 09/29/23 and requests a desk review for compliance		
E 0039 SS=C Bldg	403.748(d)(2), 410 441.184(d)(2), 483 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requii §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4 §485.625(d)(2), §4 (2), §491.12(d)(2)	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					

(X6) DATE

Brian Lessley Administrator 10/02/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W0KD21 Facility ID: 000147 If continuation sheet Page 1 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	UILDING	NSTRUCTION	(X3) DATE COMPL 08/31/	ETED
	PROVIDER OR SUPPLIER		300 WIN	DDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
PREFIX TAG	REGULATORY OF OPO, "Organizatic CMHCs at §485.9 §491.12, and ESF (2) Testing. The [for exercises to test to annually. The [fact following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the [fact natural or man-materization of the exempt from encommunity-based functional exercis actual event. (ii) Conduct an addevery 2 years, oppor functional exercis actual event. (ii) Conduct an addevery 2 years, oppor functional exercis (C) of this section include, but is not (A) A second full-community-based functional exercis (B) A mock disast (C) A tabletop exercis (B) A mock disast (C) A tabletop exercis (B) a facilitator discussion using a second full-second functional exercis (B) A mock disast (C) A tabletop exercis (B)	cons" under §485.727, 20, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan illity] must do all of the full-scale exercise that is every 2 years; or munity-based exercise is anduct a facility-based the every 2 years; or every 2 years; or fullity] experiences an actual and emergency that requires mergency plan, the [facility] the gaging in its next required or individual, facility-based the following the onset of the ditional exercise at least the posite the year the full-scale cise under paragraph (d)(2) the sconducted, that may limited to the following: the scale exercise that is or individual, facility-based the; or the ditional exercise at least the posite the year the full-scale cise under paragraph (d)(2) the conducted of the following: the scale exercise that is or individual, facility-based the provided of the following: the scale exercise that is or individual, facility-based the provided of the following: the scale exercise that is or individual, facility-based the provided of the following: the scale exercise of the following: the scale exercise that is or individual, facility-based the provided of the following: the scale exercise that is or individual, facility-based the provided of the following: the scale exercise is the scale exercise is that is the scale	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
	messages, or pre to challenge an er (iii) Analyze the [fa maintain documer	pared questions designed				

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 2 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155243	r í	UILDING	NSTRUCTION	COMPL 08/31/	ETED
	PROVIDER OR SUPPLIER			300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	*[For Hospices at (2) Testing for hose the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a command accessible, conduct based functional et (B) If the hospice of the emergency exempt from engascale community-facility-based functional exercise of the section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem stamessages, or prepto challenge an er (3) Testing for hose	spices that provide care in e. The hospice must to test the emergency ally. The hospice must do I full-scale exercise that is every 2 years; or nunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is riging in its next required full based exercise or individual etional exercise following the gency event. Iditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed					
	•	he emergency plan twice					

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 3 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
		155243	B. W	ING		08/31/	2023
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
WAJEST	IC CARE OF LAFA	YEIIE		LAFAYE	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	1 ' '	spice must do the following: an annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					
	1 ' '	ict an annual individual					
		ctional exercise; or					
	1	experiences a natural or					
		ency that requires activation					
	of the emergency	plan, the hospice is					
	exempt from enga	aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	1 ' '	dditional annual exercise					
		but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	1	or a facility based					
	functional exercise (B) A mock disas						
	1 ' '	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
	_	rio, and a set of problem					
		ed messages, or prepared					
		ed to challenge an					
	emergency plan.						
	(iii) Analyze the h	ospice's response to and					
	maintain documer	ntation of all drills, tabletop					
		nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	*[For PRETs at 8/	l41.184(d), Hospitals at					
	§482.15(d), CAHs						
	. , ,	PRTF, Hospital, CAH] must					
	1 ' '	s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	_	an annual full-scale exercise					

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 4 of 40

PRINTED: 10/05/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		155243	B. W	ING		08/31	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIE	R			NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE			ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	RRECTION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that is community						
		nunity-based exercise is not					
		uct an annual individual,					
		ctional exercise; or					
	(B) If the [PRTF,	Hospital, CAH] experiences					
		or man-made emergency					
		vation of the emergency					
		is exempt from engaging in					
	· ·	ull-scale community based					
	or individual, facil	ity-based functional exercise					
	_	et of the emergency event.					
	(ii) Conduct	an [additional] annual					
	exercise or and the	nat may include, but is not					
	limited to the follo	owing:					
		-scale exercise that is					
	community-based	d or individual, a					
	facility-based fund	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tableto	p exercise or workshop that					
	is led by a facilita	tor and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	atements, directed					
		pared questions designed					
	to challenge an e	mergency plan.					
	(iii) Analyze t	the [facility's] response to					
	and maintain doc	umentation of all drills,					
	tabletop exercise	s, and emergency events					
	and revise the [fa	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	, , =					
	· ,	PACE organization must					
		s to test the emergency					
	plan at least annu	-					
	_	t do the following:					
		an annual full-scale exercise					
	that is community	/-based; or					

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

(A) When a community-based exercise is not accessible, conduct an annual individual,

Event ID:

 $W0KD21 \quad \ \ {\rm Facility\ ID:} \quad \ 000147$

Page 5 of 40 If continuation sheet

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED 08/31/2023	
NAME OF F	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD	•	
MAJEST	IC CARE OF LAFA	YETTE		ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE DPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	1	ctional exercise; or				
	1 ' '	xperiences an actual natural				
		ergency that requires				
		mergency plan, the PACE				
	-	gaging in its next required				
		nity based or individual,				
	onset of the emer	ctional exercise following the				
		in additional exercise every				
	, ,	the year the full-scale or				
	1 .	e under paragraph (d)(2)(i)				
		conducted that may include,				
	but is not limited to	•				
		scale exercise that is				
	1 ' '	or individual, a facility				
	based functional e	_				
	(B) A mock disas	ter drill; or				
	(C) A tabletop ex	ercise 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 sta					
		pared questions designed				
	to challenge an er					
	1 ' '	PACE's response to and				
		ntation of all drills, tabletop				
		nergency events and revise				
	i the PACE's emero	gency plan, as needed.				
	*[For LTC Facilitie	es at §483.73(d):]				
	(2) The [LTC facili	ity] must conduct exercises				
	to test the emerge	ency plan at least twice per				
	1 -	announced staff drills using				
		ocedures. The [LTC facility,				
	ICF/IID] must do t	_				
		an annual full-scale exercise				
	that is community					
	1 ' '	nunity-based exercise is not				
		ict an annual individual,				
	facility-based fund	ctional exercise.				

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

Event ID:

 $W0KD21 \quad \ \ {\rm Facility\ ID:} \quad \ 000147$

If continuation sheet

Page 6 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155243	A. BUILDING B. WING	G <u></u>	COME	PLETED 1/2023
NAME OF I	PROVIDER OR SUPPLIEF			EET ADDRESS, CITY, STATE, ZIP CO	DD	
MAJEST	IC CARE OF LAFA	YETTE		WINDY HILL DR FAYETTE, IN 47905		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
		ility] facility experiences an				
		nan-made emergency that n of the emergency plan, the				
		mpt from engaging its next				
		le community-based or				
	1	based functional exercise				
	_	et of the emergency event.				
	_	dditional annual exercise				
	that may include,	but is not limited to the				
	following:					
	' '	scale exercise that is				
		or an individual, facility				
	based functional e	·				
	(B) A mock disas					
		ercise or workshop that is				
	led by a facilitator					
	discussion, using					
	_	emergency scenario, and a				
	set of problem sta	pared questions designed				
	to challenge an er					
	_	_TC facility] facility's				
		naintain documentation of				
		exercises, and emergency				
		the [LTC facility] facility's				
	emergency plan, a					
	*[For ICF/IIDs at §	• • •				
		CF/IID must conduct				
		he emergency plan at least				
		e ICF/IID must do the				
	following:					
		n annual full-scale exercise				
	that is community	-based; or nunity-based exercise is not				
	` '	ct an annual individual,				
		ct an annual individual, tional exercise; or.				
	1	experiences an actual				
		ade emergency that requires				
		mergency plan, the ICF/IID				
	I		I			I

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 7 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155243	B. W	ING		08/31/	/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUFFLIER			300 WII	NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAYE	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	-	gaging in its next required					
		nity-based or individual,					
		tional exercise following the					
	onset of the emer	-					
	' '	ditional annual exercise					
	I -	but is not limited to the					
	following:	scale exercise that is					
	community-based	ctional exercise; or					
	(B) A mock disast						
	` '	ercise or workshop that is					
	` '	and includes a group					
	discussion, using	.					
		emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	· · · · · · · · · · · · · · · · · · ·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	*[Eor ULIA - ot 946	04 1001					
	*[For HHAs at §48						
		e HHA must conduct					
		he emergency plan at e HHA must do the					
	following:	e nna must do me					
		full-scale exercise that is					
	community-based						
		ommunity-based exercise					
	` '	conduct an annual					
		based functional exercise					
	every 2 years; or.						
		A experiences an actual					
	` ′	ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		tional exercise following the					

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 8 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155243	B. W	ING		08/31/	/2023
NAME OF F	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAYE	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	onset of the emer	-					
	' '	ditional exercise every 2					
	•	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	•					
		limited to the following:					
	, ,	full-scale exercise that is					
	community-based						
	facility-based fund						
	, ,	isaster drill; or					
	, ,	exercise or workshop that					
	discussion, using	or and includes a group					
		· ·					
	set of problem sta	emergency scenario, and a					
	-	pared questions designed					
	to challenge an er						
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	The firm to emerge	only plan, as needed.					
	*[For OPOs at §48	•					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	_					
		er-based, tabletop exercise					
		ast annually. A tabletop					
		a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	•	its, directed messages, or					
		ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
	•	of the emergency plan, the					
	-	om engaging in its next					
		xercise following the onset					
	of the emergency						
	(ii) Analyze the Of	PO's response to and	1				

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 9 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLET				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155243	B. WI	NG	_	08/31/	2023
	PROVIDER OR SUPPLIER			300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AVIOR CONNECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
TAG	maintain documer exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paperat least annually. If group discussion In narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record reversible for the conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based function in the LTC facility or man-made emergency plan from engaging its necommunity-based on the community-based of the emergency plan and the emergency plan and the community-based of the emergency plan and the emergency p	attation of all tabletop bergency events, and revise OPO's] emergency plan, as a 3.748]: RNHCI must conduct the emergency plan. The bergency plan. The bergency plan as a description of all tabletop exercise and tabletop exercise is a ded by a facilitator, using a description of problem statements, and revise and emergency plan. The bergency plan as needed and tabletop dergency events, and revise regency plan, as needed and interview, the facility ercises to test the emergency er year, including derills using the emergency C facility must do the annual full-scale exercise that an annual individual,	E 00		p="" paraid="1097784388" paraeid="{47268172-2afa-4c9 f-ec171fac4e36}{216}"> p="" paraid="1097784388" paraeid="{677b1054-b894-4fa f-fa9b917165a1}{200}">039 w corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; p="" paraid="1985904605" paraeid="{677b1054-b894-4fa f-fa9b917165a1}{217}">An an exercise led by the Maintenan Director or designee that inclu a group discussion using a narrated, emergency scenario	6-936 hat nts y the 6-936 nual ce des	10/02/2023
	1 1	itional exercise that may mited to the following:			a set a problem statements an prepared questions designed to challenge the emergency plan	to	

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 10 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	<u></u>	COMPLETED	
		155243	B. W	ING		08/31/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>	
NAME OF I	PROVIDER OR SUPPLIE	R			NDY HILL DR		
MA IEST	IC CARE OF LAFA	VETTE			ETTE, IN 47905		
IVIAJEST	IC CARE OF LAFA	110110		LAFAT	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	a. A second full-sca				be scheduled was conducted	on	
	1	or an individual, facility-based			09/28/23 and a second one		
	functional exercise.				scheduled to occur on or befo	re	
	b. A mock disaster drill; or				12/31/23. how other residents	3	
	_	ise or workshop that is led by a			having the potential to be affe	cted	
		ides a group discussion, using			by the same deficient practice	: will	
		ly relevant emergency scenario,			be identified and what correct	ive	
		m statements, directed			action(s) will be taken; All		
		red questions designed to			residents have the potential to	be	
	challenge an emerg				affected.		
		ΓC facility's response to and			p="" paraid="801539566"		
		tation of all drills, tabletop			paraeid="{677b1054-b894-4fa	a6-936	
		rgency events, and revise the			f-fa9b917165a1}{254}"> what		
	1	rgency plan, as needed in			measures will be put into plac	е	
		2 CFR 483.73(d)(2). This			and what systemic changes w	<i>i</i> ill	
	deficient practice c	ould affect all occupants.			be made to ensure that the		
					deficient practice does not		
	Findings include:				recur: exercises will be		
					pre-scheduled by the mainten		
		eview and interview with the			director or . The upcoming da	tes	
	_	rvisor on 08/31/23 at 12:50 p.m.,			will be reviewed in the daily		
	-	able to provide documentation			standup meeting with the		
	of an annual full-sc				interdisciplinary team on a we	ekly	
	1	an annual individual,			basis until they occur.		
		tional exercise, a second			p="" paraid="1831587151"		
		that is community-based or an			paraeid="{9d84d1a4-91ee-43		
	-	-based functional exercise, a			8c-06b59af70675}{44}"> Each		
		or a tabletop exercise or			month, the Maintenance direc	tor	
	•	d by a facilitator that includes a			or will ensure that there a		
	group discussion, u				minimum of 2 facility exercise	s to	
		emergency scenario, and a set			test the emergency plan		
	_	ents, directed messages, or			scheduled over the coming 12	<u>'</u>	
		designed to challenge an			months. how the corrective		
	emergency plan.				action(s) will be monitored to		
		at the time of record review,			ensure the deficient practice v	vill	
		upervisor agreed that			not recur, i.e., what quality		
		any of the aforementioned drills			assurance program will be pu	t into	
		not available for review as of			place;		
	the time of this sur	vey.			The scheduled dates and pro		
					execution of the annual exerc	ise	

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155243	JILDING	NSTRUCTION	COMPL 08/31/	ETED
	PROVIDER OR SUPPLIER		300 WIN	NDDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Administrator and the 08/31/23 at 3:25 p.m.	ference with the facility the Maintenance Supervisor on the Maintenance Information or the maintenance Supervisor on the Maint		will be reviewed in the QAA meeting to ensure: That there always a minimum of 2 exercis planned on a rolling basis and all scheduled exercises for that month are completed properly according to the schedule. Mis exercises for the month will be promptly re-scheduled to occu within the next and before 12/31/23. p="" paraid="898912571" paraeid="{df1f3c3c-69f6-45f6-499c7f94a9a7}{52}">	ses that t and sed	
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan set this section and in procedures plan set (i) and (ii) of this section and in procedures plan set) and (ii) of this section and the procedures plan set) and (iii) of this section and (iii)	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Ind the CAH] must ency and standby power the emergency plan set (a) of this section.				
	Emergency generator must be the location requirement Care Facilities Continued Interim Amendment	33.73(e)(1), §485.625(e)(1) ator location. The located in accordance with ements found in the Health de (NFPA 99 and Tentative hts TIA 12-2, TIA 12-3, TIA				

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 12 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	 UILDING	NSTRUCTION	(X3) DATE COMPL 08/31/	ETED
	PROVIDER OR SUPPLIEF		300 WIN	NDDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built o structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the em inspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §483 Emergency gener and LTC facilities] source to power en have a plan for ho power systems on emergency, unless *[For hospitals at §483.73(g), and C The standards ince this section are ap reference by the E Federal Register if 552(a) and 1 CFR the material from You may inspect a Information Resou Boulevard, Baltim	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system and [maintenance] and in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must be wit will keep emergency perational during the sit evacuates. §482.15(h), LTC at EAHs §485.625(g):] corporated by reference in peroved for incorporation by Director of the Office of the in accordance with 5 U.S.C. apart 51. You may obtain the sources listed below. In a copy at the CMS arce Center, 7500 Security ore, MD or at the National	TAG		ALE	DATE
	(NARA). For informathis material at NA go to: http://www.archive	ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html.				

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 13 of 40

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		A. BU	A. BUILDING B. WING			COMPLETED 08/31/2023	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD NDY HILL DR		
MAJEST	C CARE OF LAFA	/ETTE			ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	incorporated by redocument in the Fannounce the char (1) National Fire FBatterymarch Parl Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Healt 2012 edition, issued (ii) Technical interi NFPA 99, issued // (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xii) NFPA 110, S Standby Power Sy including TIAs to C 2009.	rotection Association, 1 K, D, www.nfpa.org, The Care Facilities Code, The August 11, 2011. The Amendment (TIA) 12-2 to August 11, 2011. The A99, issued August 9, The PA 99, issued March 7, The PA 99, issued August 1, The PA 99, issued March 3, The Safety Code, 2012	E 00	041	p paraid="2859918"		09/29/2023
	failed to implement inspection, testing a found in the Health 110, and Life Safety	the emergency power system nd maintenance requirements Care Facilities Code, NFPA 7 Code in accordance with 42 This deficient practice could	EUU	<i>J</i> +1	p paraid= 2659916 paraeid="{9d84d1a4-91ee-436 8c-06b59af70675}{157}" >E04		U31 231 2U23

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 14 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED		
		155243	B. W	ING		08/31/	/2023	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF F	ROVIDER OR SUFFLIER			300 WI	NDY HILL DR			
MAJEST	IC CARE OF LAFA	YETTE		LAFAY	ETTE, IN 47905			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE	
TAG		RY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY)		
	affect all occupants.					_		
	1) David an accord				what corrective action(s) will be			
		review and interview, the			accomplished for those reside			
		sure a written record of weekly generator was maintained for			found to have been affected b	y ine		
	_	PA 99, 6.4.4.1.3 requires onsite			deficient practice;			
		maintained in accordance with						
	_	rd for Emergency and Standby			p paraid="219745348"			
		FPA 110, 8.4.1 requires an			paraeid="{9d84d1a4-91ee-43	-8-h4		
	-	Supply System (EPSS)			8c-06b59af70675}{174}" >	00 0 1		
	including all appurtenant components, shall be							
	inspected weekly and exercised monthly. NFPA							
	99, 6.4.4.2 requires a written record of inspection,				The maintenance director will	be		
	performance, exercising period, and repairs for the				educated on inspection of			
	generator to be regu	ılarly maintained and available			emergency power systems for	the		
	for inspection by th	e authority having			facility.			
	-	eficient practice could affect all						
	residents, staff, and	visitors.						
	Findings include:				how other residents having the	۵.		
					potential to be affected by the	-		
	Based on record rev	view on 08/31/23 at 11:40 a.m.			same deficient practice will be			
	with the Maintenan	ce Supervisor, documentation			identified and what corrective			
	for January 1, 2023	through May 22, 2023 along			action(s) will be taken;			
	with 06/14/23, 06/2	1/23, and 06/28/23 weekly						
	generator testing wa	as not available for review.						
		ew at the time of record review,						
		pervisor confirmed weekly						
	-	d not occur during the			p paraid="1133102267"			
		es because the previous			paraeid="{9d84d1a4-91ee-43	e8-b4		
	1	visor failed to conduct the			8c-06b59af70675}{199}" >All			
	testing.				residents have the potential to	be		
	D : d :	6 44635			affected.			
	_	ference with the facility						
		he Maintenance Supervisor on						
	_	m., no additional information or						
	-	provided contrary to this			what magazings will be much into			
	deficient finding.				what measures will be put into			
	2) Rasad on record	review and interview, the			place and what systemic char will be made to ensure that the			
	2) Dasca on record	review and interview, the	ı		I will be made to ensure that the	5	I	

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/31/2023			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY) deficient practice does no	LD BE COMPLETION DATE			
	the emergency electoric accordance with NI Emergency and States 8. NFPA 110 8.4.2 service to be exercing minimum of 30 min 99 requires a written performance, exercing generator to be registered for inspection by the	trical system to be in FPA 110, the Standard for Indby Powers Systems, Chapter requires diesel generator sets in sed at least once monthly, for a nutes. Chapter 6.4.4.2 of NFPA In record of inspection, ising period, and repairs for the ularly maintained and available		All weekly generator insp will be conducted and documentation will be monitored for completion Administrator weekly to e the generator test was coweekly.	cumented nt TELS designee e by ensure			
	with the Maintenan of Monthly testing generator was not a 1, 2023 through Ma interview at the tim Maintenance Super generator testing di aforementioned dat	view on 08/31/23 at 11:42 a.m. ce Supervisor, documentation of the facilities diesel-powered vailable for review for January by 20, 2023. Based on an e of record review, the visor confirmed that monthly d not occur during the es because the previous visor failed to conduct the		All monthly generator insignifications will be conducted and documentation will be monitored for completion Administrator monthly to the generator test was conveekly.	cumented nt TELS designee e by ensure			
	Administrator and to 08/31/23 at 3:29 p.s. evidence could be prediction finding. 3) Based on record facility failed to except the second seco	ference with the facility the Maintenance Supervisor on m., no additional information or provided contrary to this review and interview, the ercise the generator annually to nts of NFPA 110, 2010 Edition,		p paraid="137243891" paraeid="{a40c7c8e-4776 0-155e95c3785f}{21}" >	e-4235-afa			

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 16 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		A. BUILDING B. WING		COMPLETED 08/31/2023	
NAME OF P	ROVIDER OR SUPPLIER	- -		ET ADDRESS, CITY, STATE, ZIP COD WINDY HILL DR	
MAJESTI	C CARE OF LAFA	YETTE		AYETTE, IN 47905	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION
TAG		nergency and Standby Powers	TAG	how the corrective action(s) v	5.112
		4.2. Section 8.4.2 states diesel		monitored to ensure the defic	
		vice shall be exercised at least		practice will not recur, i.e., wh	
	once monthly, for a	minimum of 30 minutes, using		quality assurance program w	
	one of the following			put into place	
		intains the minimum exhaust			
		recommended by the			
	manufacturer	temperature conditions and at		The weekly generator in a	tions
		-		The weekly generator inspectings in TELS will be reviewed	
	not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.			the monthly QAA meeting to	1 ""
	Section 8.4.2.3 states diesel-powered EPS			ensure the inspections have	been
	installations that do not meet the requirements of			conducted each week per	
	8.4.2 shall be exercised monthly with the available			regulation. Any missed week	dy
		Power Supply System) load and		generator inspections will be	
		nnually with supplemental		immediately will be provided	to the
	· ·	est) at not less than 50 percent		Maintenance Director.	
	_	te kW rating for 30 continuous ess than 75 percent of the EPS			
		g for 1 continuous hour for a			
		f not less than 1.5 continuous		The monthly generator inspe	ctions
		t practice could affect all		logs in TELS will be reviewed	
	occupants.	•		the monthly QAA meeting to	
				ensure the inspections have	been
	Findings include:			conducted each month per	
				regulation. Any missed mont	thly
		riew on 08/31/23 at 11:44 a.m.		generator inspections will be	to the
		ce Supervisor, the load the actual load percentage for		immediately will be provided Maintenance Director.	to the
		generator was not being		Ivialitieriance Director.	
		on interview at the time of			
		Maintenance Supervisor			
	acknowledged the g	enerator ran under load on a			
		d not achieve 30 % of the		p="" paraid="2859918"	
		Additionally, the Maintenance		paraeid="{df1f3c3c-69f6-45f6	6-88fe-
		edged a load bank test for the		a99c7f94a9a7}{81}">	
	_	ccurred within the past			
	twelve-month perio	u.			
	During the exit con	ference with the facility			

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

Event ID:

 $W0KD21 \quad \ \ {\rm Facility\ ID:} \quad \ 000147$

If continuation sheet

Page 17 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MUI A. BUII B. WIN	DING	NSTRUCTION	(X3) DATE : COMPL 08/31/	ETED
	PROVIDER OR SUPPLIER			300 WIN	DDRESS, CITY, STATE, ZIP COD IDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
1AG	Administrator and to 08/31/23 at 3:29 p.r. evidence could be providence could be providence. 4) Based on record facility failed to ensure was performed for the generator. NFPA 9 2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. In maintenance shall be with NFPA 110, Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect with the Maintenance could affect be maintenance of a section of an interviet of the Maintenance Sure annual fuel quality because the previous failed to request the During the exit come Administrator and to 08/31/23 at 3:29 p.r.	he Maintenance Supervisor on m., no additional information or provided contrary to this review and interview, the mure an annual fuel quality test the facility's diesel-powered 9, Health Care Facilities Code, m 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states the performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests is standards. This deficient		IAG	DEFLEXIT		DATE
K 0000							

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 18 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155243		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE : COMPL 08/31/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg. 01	Licensure Survey w	00147 155243	K 00	000	Majestic Care of Lafayette submits this POC as our credit allegation of compliance as of 09/29/23 and requests a desk review for compliance		
	Lafayette was found Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L	Code survey, Majestic Care of I not in compliance with articipation in 42 CFR Subpart 483.90(a), re, and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	Type V (111) constructions sprinklered. The far with smoke detection open to the corridor detectors in all residuals.	ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, spaces s and battery powered smoke lent sleeping rooms. The ty of 122 and had a census of s survey.					
	access were sprinkle facility services wer detached storage ga	residents have customary ered. All areas which provide re sprinklered except for two rages which were used to quipment, that were not					
	Quality Review con	npleted on 09/07/23					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W0KD21 Facility ID: 000147

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION CONST	(X3) DATE SURVEY COMPLETED 08/31/2023		
	PROVIDER OR SUPPLIER		300 W	STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0211 SS=E Bldg. 01	discharges, exit lot in accordance with of egress is continual obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 or continuously maintour impediments to fire or other emergency could affect as many the facility. Findings include: Based on observation facility with the Mathematical many obstructed by two country and a 55-gallon transinterview at the time Maintenance Superwas obstructed and during an emergency evacuation of the kind During the exit con Administrator and to 08/31/23 at 3:29 p.1	ays, corridors, exit acations, and accesses are in Chapter 7, and the means accessly maintained free of full use in case of se modified by 18/19.2.2 1	K 0211	p="" paraid="147850160" paraeid="{df1f3c3c-69f6-45f6-8 a99c7f94a9a7}{183}" K211 ul class="BulletListStyle1 SCXW264281058 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdan; what corrective action(s) will be accomplished for those resident found to have been affected by deficient practice; The obstructions in the service corridor leading back to the kitchen were removed. how other residents having the potential to be affected by the	a;" ts the	

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 20 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION			01	COMPLETED 08/31/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
				same deficient practice will be identified and what corrective action(s) will be taken;				
				p paraid="1383567855" paraeid="{a40c7c8e-477e-423 0-155e95c3785f}{166}" >	35-afa			
				All residents have the potential be affected.	al to			
				what measures will be put into place and what systemic char will be made to ensure that th deficient practice does not rec	nges e			
				The dietary manager, mainter director or will ensure that obstructions in the service cor leading to the kitchen area fre from obstructions that would degress.	ridor e			
				The maintenance director and kitchen staff will be on the regulations regarding obstruct to egress and related safety issues that caused by them.				
				The Maintenance Director or v	will			

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 21 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 2 01	(X3) DATE SURVEY COMPLETED 08/31/2023	
	PROVIDER OR SUPPLIER IC CARE OF LAFAYETTE	300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(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	
			monitor the service corridor 3 x weekly for obstructions that wou create delayed egress and correany findings immediately.		
			p paraid="703955531" paraeid="{a40c7c8e-477e-4235 0-155e95c3785f}{231}" >	i-afa	
			how the corrective action(s) will monitored to ensure the deficiel practice will not recur, i.e., what quality assurance program will I put into place; and	nt :	
			The findings of weekly service corridor monitoring will be revie in the QAA meeting for 6 month		
			ul="" role="list"		
K 0347 SS=F Bldg. 01	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	W 02.47	V247	00/22/2022	
	Based on record review, observation, and interview; the facility failed to ensure documentation for the preventative maintenance of 84 of 84 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious	K 0347	K347 p paraid="51284586" paraeid="{c5aaa1e7-d551-4c6f- e-f7640424f884}{88}" >	-b90 09/23/2023	

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

Event ID:

 $W0KD21 \quad \ \ {\rm Facility\ ID:} \quad \ 000147$

If continuation sheet

Page 22 of 40

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155243	B. W	ING		08/31/	/2023
NAME OF P	ROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
			300 WINDY HILL DR				
MAJESTI	IC CARE OF LAFA	AYEIIE		LAFAY	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE	1 -	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION trequired by the Code, shall be	1	TAG			DATE
	_	-			what corrective action(s) will I accomplished for those reside		
	maintained. This deficient practice could affect all residents, staff, and visitors within the facility.				found to have been affected by the		
					deficient practice;	, a.o	
	Findings include:			denoient practice,			
	Based on record review on 08/31/23 at 12:45 p.m. with the Maintenance Supervisor, there was no						
			1		The Maintenance Director wil	l h -	
		ident rooms battery operated				ı be	
		ed for functionality on a	1		educated on regulatory requirements of testing of sm	oke	
		eleven of the last twelve			detectors as well as weekly	ONG	
	-	ore, there was no weekly			preventative testing		
	preventative maint	enance testing documentation			documentation.		
	as well. This was a	cknowledged by the					
	_	rvisor at the time of record					
		observations during a tour of					
	-	e Maintenance Supervisor,					
		noke alarms were observed in			ul class="BulletListStyle1		
	all resident sleepin	g rooms.			SCXW183145791 BCX8" role="list" style="margin: 0px;		
	During the exit cor	nference with the facility			padding: 0px; user-select: tex		
	_	the Maintenance Supervisor on			-webkit-user-drag: none;	,	
		m., no additional information or			-webkit-tap-highlight-color:		
	evidence could be	provided contrary to this			transparent; overflow: visible;		
	deficient finding.				cursor: text; font-family: verda	ana;"	
					how other residents having th		
	3.1-19(b)				potential to be affected by the		
					same deficient practice will be		
					identified and what corrective		
					action(s) will be taken;		
					All residents have the potential	al to	
			1		be affected.		
			1		what measures will be put into	D	
			1		place and what systemic char		
					will be made to ensure that th	-	

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

Event ID:

W0KD21 Facility ID: 000147

Page 23 of 40 If continuation sheet

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	F OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/31/2023		
	ROVIDER OR SUPPLIER C CARE OF LAFA		STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
				deficient practice does not recur;			
				Monthly testing of all smoke alarms will be conducted and documented by the Maintena Director or and recorded electronically into the existing TELS system.	ance		
				Weekly preventative testing of smoke alarms will be conduct by the Maintenance Director and recorded electronically in the existing TELS system.	ted or		
				ul class="BulletListStyle1 SCXW183145791 BCX8" role="list" style="margin: 0px padding: 0px; user-select: te: -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible cursor: text; font-family: verd how the corrective action(s) monitored to ensure the defic practice will not recur, i.e., wi quality assurance program we put into place	xt; ; ana;" will be cient hat		
				The results of the monthly ar weekly preventative testing of			

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 24 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED B. WING 08/31/2023			
		155243	B. WII	<u> </u>		08/31/	/2023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF LAFA	YETTE			NDY HILL DR ETTE, IN 47905		
	1				T		T
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	DATE
					smoke detectors as recorded	in	
					the TELS system will be revie	wed	
					for timeliness and accuracy in	the	
					QAA meeting for 6 months.		
K 0353	NFPA 101						
SS=F	Sprinkler System	- Maintenance and Testing					
Bldg. 01	Sprinkler System	- Maintenance and Testing					
	·	er and standpipe systems					
		sted, and maintained in					
		NFPA 25, Standard for the					
		ng, and Maintaining of					
		e Protection Systems. m design, maintenance,					
		sting are maintained in a					
		nd readily available.					
		r system last checked					
	b) Who provided						
		<u> </u>					
	c) Water system	i suppiy soulce					
	Provide in REMA	RKS information on					
	coverage for any	non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8						
		view and interview, the facility	K 03	553	p paraid="1678069109"		09/29/2023
		sprinkler system inspections in			paraeid="{c5aaa1e7-d551-4c6		
		FPA 25. NFPA 25, Standard for			e-f7640424f884}{244}" >K353	i	
	_	sting, and Maintenance of Protection Systems, 2011					
		2.4.1 states gauges on wet pipe					
		shall be inspected monthly to					
		e in good condition and that			what corrective action(s) will be	е	
		ly pressure is being maintained.			accomplished for those reside		
		tes gauges on dry pipe sprinkler			found to have been affected b		

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 25 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	 UILDING	onstruction 01	(X3) DATE COMPL 08/31 /	ETED
	PROVIDER OR SUPPLIEF		300 WII	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	normal air and water maintained. Section department connect tested, and maintain 13. Section 13.1.1.2	pected weekly to ensure that er pressures are being 5.1.2 states valves and fire ions shall be inspected, and in accordance with Chapter 2 states Table 13.1.1.2 shall be		deficient practice; The Maintenance Director will educated on regulatory		
	valves, valve comp states records shall tests, and maintena components and sha authority having jui	on, testing and maintenance of onents and trim. Section 4.3.1 be made for all inspections, nee of the system and its all be made available to the risdiction upon request. This		requirements regarding weekl gauge inspections as well as monthly inspection documents for all wet sprinkler system gauges and monthly inspectio all sprinkler system control	ation	
	deficient practice co and visitors. Findings include:	ould affect all residents, staff,		p paraid="418888906"	10 h -	
	report "Sprinkler: R documentation for t	the facility's sprinkler vendor eport of Inspection" he most recent twelve-month		paraeid="{c90da9cd-3c77-4ccc1-873f7d6c7606}{58}" >	i3-be	
	record review at 11 sprinkler system ga for 33 weeks of the was not available for sprinkler system ga for four months of the sprinkler system.	ntenance Supervisor during 15 a.m. on 08/31/23, weekly dry uge inspection documentation most recent 52-week period or review. Monthly wet uge inspection documentation he most recent twelve-month available for review. In		how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.		
	addition, monthly in all sprinkler system the most recent 12 in for review. Based of record review, the Macknowledged sprin	nspection documentation for control valves for 4 months of month period was not available on interview at the time of Maintenance Supervisor akler system gauge and control		All residents have the potential be affected.	al to	
	not available for rev During the exit con	ekly and monthly periods was		ul class="BulletListStyle1 SCXW117463394 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text -webkit-user-drag: none; -webkit-tap-highlight-color:	t;	

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 26 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155243	 UILDING	01	COMPL 08/31/	ETED
	PROVIDER OR SUPPLIER		300 WIN	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	-	n., no additional information or rovided contrary to this		transparent; overflow: visible; cursor: text; font-family: verdal what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recommend.	ges e	
				The Maintenance Director or viconduct weekly dry sprinkler gauge inspection and record the in the existing TELS system. Maintenance Director or design will conduct monthly inspection of all wet sprinkler system gaus as well as monthly inspections all sprinkler system control valund record the existing TELS system	hem The nee ns ges s of	
				how the corrective action(s) w monitored to ensure the deficient practice will not recur		
				The results of the weekly dry sprinkler gauge inspections, the monthly inspections of the well sprinkler system gauges and monthly inspection of all sprinkly system control valves will be reviewed for timeliness and accuracy in the QAA meeting months.	der	

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 27 of 40

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243 NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF LAFAYETTE ID PROVIDERS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF LAFAYETTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	i
MAJESTIC CARE OF LAFAYETTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET	
CROSS-REFERENCED TO THE APPROPRIATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY DATE	.ON
1,007,1	
K 0374 NFPA 101	
SS=E Subdivision of Building Spaces - Smoke	
Bldg. 01 Barrie	
Subdivision of Building Spaces - Smoke	
Barrier Doors	
2012 EXISTING	
Doors in smoke barriers are 1-3/4-inch thick	
solid bonded wood-core doors or of	
construction that resists fire for 20 minutes.	
Nonrated protective plates of unlimited height	
are permitted. Doors are permitted to have	
fixed fire window assemblies per 8.5. Doors	
are self-closing or automatic-closing, do not	
require latching, and are not required to swing	
in the direction of egress travel. Door opening	
provides a minimum clear width of 32 inches	
for swinging or horizontal doors.	
19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility K 0374 K374 09/29/2	022
	J23
failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least p paraid="1013275627" paraeid="{c90da9cd-3c77-4cd3-be}	
20 minutes. LSC, Section 19.3.7.8 requires that c1-873f7d6c7606}{191}" >	
doors in smoke barriers shall comply with LSC,	
Section 8.5.4. LSC, Section 8.5.4.1 requires doors	
in smoke barriers to close the opening leaving what corrective action(s) will be	
only the minimum clearance necessary for proper accomplished for those residents	
operation which is defined as 1/8 inch to restrict found to have been affected by the	
the movement of smoke. This deficient practice deficient practice;	
affects 16 residents, 3 staff, and 2 visitors.	
Findings include:	
The gap along occurring in the set	ļ
Based on observations made during a tour of the of smoke barrier doors nearest to	
facility with the Maintenance Supervisor on the Medical Records office was	ļ
08/31/23 at 1:45 p.m., the set of smoke barrier corrected.	ļ
doors nearest to the Medical Records office had a	ļ
one-inch gap along the center where the doors	ļ
came together in the closed position. This was	ļ
verified by the Maintenance Director at the time of	ļ
observation who added that he had worked on ul class="BulletListStyle1"	

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 28 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/31/2023	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
MAJEST	IC CARE OF LAFA	YETTE		YETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	these doors before a close as soon as post During the exit con Administrator and t 08/31/23 at 3:29 p.1	and would get them to fully	TAG	SCXW187053149 BCX8" role="list" style="margin: 0px padding: 0px; user-select: tex-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible cursor: text; font-family: verd how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential be affected. measures will be put into plate and what systemic changes where the deficient practice does not resident pract	; ana;" ne e e e e e e e e e e e e e e e e e e

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 29 of 40

PRINTED: 10/05/2023

DEPARTMENT OF HEALTH AND HUM	FORM APPROVED			
CENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>01</u>	COMPLETED
	155243	B. WI	NG	08/31/2023
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF LAFA			STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905	•

	IC CARE OF LAFAYETTE		LAFAYETTE, IN 47905				
(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			
			quality assurance program will be put into place.				
			The results of the monthly audits will be reviewed to ensure proper functioning of smoke barrier doors in QAA for 6 months.				
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 Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters within the last 12 months. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 08/31/23 at 11:34 a.m. with the Maintenance Supervisor, documentation could not be provided regarding a fire drill for the first quarter (January, February, and March) of	K 0712	K712 p paraid="709081579" paraeid="{717a9229-7a7e-4aaf-b61 7-2c0115e55ca2}{70}" > what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	09/29/2023			

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

Event ID: W0KD21 Facility ID: 000147

If continuation sheet

Page 30 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		A. BUILDING B. WING	01	COMPLETED 08/31/2023	
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR 'ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	May, and June) fire second, or third shif at the time of record Supervisor acknowl additional fire drill of	ift or a second quarter (April, drill for 2023 on the first, its in 2023. Based on interview I review, the Maintenance edged that there was no documentation available for		The Maintenance Director will educated on the regulatory for proper conducting of fire drills	r the
	Administrator and the 08/31/23 at 3:29 p.m.	ference with the facility the Maintenance Supervisor on n., no additional information or rovided contrary to this		ul class="BulletListStyle1 SCXW158247595 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: tex- -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verda how other residents having th potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.	na;" e
				All residents have the potential be affected.	al to
				measures will be put into place and what systemic changes we be made to ensure that the deficient practice does not reconstruction.	rill
				p paraid="1861668446" paraeid="{717a9229-7a7e-4a 7-2c0115e55ca2}{125}" >	af-b61
				The Maintenance director or v	

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 31 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		A. BUILDING B. WING	01	COMPLETED 08/31/2023	
	ROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP COD NDY HILL DR ETTE, IN 47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				with the regulatory requirement and record the results.	nts
				how the corrective action(s) w monitored to ensure the defici practice will not recur.	
				The results of documented fire drills will be reviewed for timeliness, accuracy and cont in the QAA meeting for 6 mon	ent
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, rediffered by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a less than or equal the LIM test switch activates both visual LIM circuits with a manual test is performed.	- Maintenance and - Maintenance at particular and a tested at intervals - Maintenance data Maintenance data and - Maintenance data Maintenance data and - Maintenance data Maintenance data and - Maintenance data and - Maintenance data - Maintenance and - M			

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 32 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		ľ í	JILDING	ONSTRUCTION <u>01</u>	(X3) DATE COMPL 08/31 /	ETED	
	OF PROVIDER OR SUPPLIED			STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99) Based on observati interview; the facilielectrical receptacles sleeping rooms. NF Code 2012 Edition receptacles not listed bed locations and in sedation or general shall be tested at in months. Additional Testing in Patient Cophysical integrity of confirmed by visual the grounding circushall be verified. Concutral connections shall be confirmed; grounding blade of (except locking-type than 115 gram (4 or could affect all resisted in the Maintenant receptacle retention the physical integrity the resident room resident	electric distribution system. Itained of required tests and so or modifications, from or area tested, and on, record review and fity failed to ensure 588 of 588 es were tested in resident five factions. Section 6.3.4.1.3 states and as hospital-grade, at patient in locations where deep anesthesia is administered, tervals not exceeding 12 ly, Section 6.3.3.2, Receptacle for according to the feach receptacle shall be a linspection. The continuity of the in each electrical receptacle and retention force of the each electrical receptacle and retention force of the each electrical receptacle are receptacles) shall be not less tunces). This deficient practice	K 0	914	p paraid="1885075600" paraeid="{0aa425de-3f2b-463 0-a8d798a48f73}{37}" >K914 what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice. p paraid="1305108723" paraeid="{0aa425de-3f2b-463 0-a8d798a48f73}{54}" > The Maintenance Director will educated on the regulatory requirement for receptacle retention testing for physical integrity, continuity and polarity how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.	one on the one of the	DATE 09/29/2023

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 33 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 08/31/2023				
		155243	B. W	ING		08/31/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
			300 WINDY HILL DR				
MAJEST	IC CARE OF LAFA	YEIIE		LAFAY	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Maintenance Supervisor	+	TAG	DEFICIENCY		DATE
		documentation of testing per					
		ele Testing requirements			p paraid="856208392"		
	because the previous Maintenance Supervisor failed to conduct the testing.				paraeid="{0aa425de-3f2b-463	30-9c3	
					0-a8d798a48f73}{85}" >All		
					residents have the potential to	be	
	3.1-19(b)				affected.		
					measures will be put into place	ce	
					and what systemic changes w		
					be made to ensure that the		
					deficient practice does not rec		
					Receptacle testing in all reside	ent	
					rooms will be conducted by th		
					maintenance director or desig		
					to ensure all receptacles are		
					visually inspected, verification	of	
					the continuity of the grounding	-	
					circuit, correct polarity of the h		
					and neutral connections confi	rmed	
					and retention force of the		
					grounding blade for each		
					receptacle is checked.		
					p paraid="1259794289"		
					paraeid="{0aa425de-3f2b-463	30-9c3	
					0-a8d798a48f73}{130}" >		
					The regulte of all resemble 1		
					The results of all receptacle testing will be recorded in TEL	9	
					and reviewed weekly in the	_0	
					morning stand-up meeting wit	h the	

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

Event ID:

 $W0KD21 \quad \text{Facility ID:} \quad 000147 \qquad \qquad \text{If continuation sheet} \quad \text{Page 34 of 40}$

PRINTED: 10/05/2023

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155243	(X2) MULT A. BUILI B. WING	DING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/31/2023	
NAME OF I	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR				
MAJEST	IC CARE OF LAFA	YETTE	L	.AFAY	ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					interdisciplinary team		
					how the corrective action(s) we monitored to ensure the deficient practice will not recur.		
					The results of the receptacle testing will be reviewed in the monthly QAA meeting to ensu they are completed in their entirety. Any areas with receptacles noted not to be testing and reviewed again in next QAA until all receptacles tested and verified to be function in so far as they have been visually inspected, verified for continuity of the grounding circulated for the correct polarity of the hot and neutral connection and retention force of the grounding blade for each receptacle is verified and all as functional.	sted the are onal the cuit, of	
					p="" paraid="72163351" paraeid="{717a9229-7a7e-4aa	af-b61	

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

NFPA 101

Electrical Systems - Essential Electric Syste

Electrical Systems - Essential Electric

K 0918

SS=F

Bldg. 01

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet

Page 35 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/31/2023				
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 300 WINDY HILL DR LAFAYETTE, IN 47905					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	System Maintenance and Testing							
	The generator or	other alternate power						
	source and assoc	iated equipment is capable						
		ce within 10 seconds. If the						
		on is not met during the						
	•	ocess shall be provided to						
	-	his capability for the life						
		branches. Maintenance						
		generator and transfer						
		ormed in accordance with						
	NFPA 110.	a imama ata duna aldu.						
		e inspected weekly,						
	exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised							
		onths for 4 continuous hours.						
	-	nder load conditions include						
		ated cold start and						
	•	ual transfer of all EES						
		nducted by competent						
		enance and testing of stored						
		ırces (Type 3 EES) are in						
		NFPA 111. Main and feeder						
	circuit breakers ar	re inspected annually, and a						
	program for perio	dically exercising the						
	components is es	tablished according to						
	manufacturer requ	uirements. Written records						
		nd testing are maintained						
	and readily available. EES electrical panels							
	and circuits are marked, readily identifiable,							
		n normal power circuits.						
		ssibility of damage of the						
	• • •	r source is a design						
	consideration for							
	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		K 0918	p="" paraid="2088163203"	00/20/2022			
	*	sure a written record of weekly	K 0918	p= paraid= 2088163203 paraeid="{ee65ab1e-fc68-4d3	09/29/2023			
	-	generator was maintained for		2-59a5b8c66f87}{39}">	า-ลฮน			
		FPA 99, 6.4.4.1.3 requires onsite		p paraid="2088163203"				
		maintained in accordance with		paraeid="{0aa425de-3f2b-463	30-9c3			

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

Event ID:

W0KD21 Facility ID: 000147

If continuation sheet Page 36 of 40

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO		COMPL	COMPLETED	
1552		155243	B. WING		08/31/2023		
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			NDY HILL DR		
MAJESTIC CARE OF LAFAYETTE					ETTE, IN 47905		
MAJEST	IC CARE OF LAFA	16116		LAFATI	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		rd for Emergency and Standby			0-a8d798a48f73}{219}" >K918		
	1	FPA 110, 8.4.1 requires an					
		Supply System (EPSS)					
		tenant components, shall be					
		nd exercised monthly. NFPA					
	99, 6.4.4.2 requires a written record of inspection,						
	•	ising period, and repairs for the			what corrective action(s) will b	е	
		ılarly maintained and available			accomplished for those reside		
	for inspection by th	• •			found to have been affected b		
	, ·	eficient practice could affect all			deficient practice.		
	residents, staff, and visitors.						
	Findings include:						
					n naraid="88729463"		
	Based on record review on 08/31/23 at 11:40 a.m.				p paraid="88729463"		
	with the Maintenance Supervisor, documentation			paraeid="{0aa425de-3f2b-4630-9c3			
	for January 1, 2023 through May 22, 2023 along				0-a8d798a48f73}{240}" >The		
	with 06/14/23, 06/21/23, and 06/28/23 weekly				Maintenance Director will be		
		as not available for review.			educated on the regulatory for		
		ew at the time of record review,		weekly generator inspections, monthly generator tests and			
		pervisor confirmed weekly			annual fuel quality testing for the		
	generator testing did not occur during the				diesel generator.		
	aforementioned dates because the previous				diesei generator.		
	Maintenance Supervisor failed to conduct the						
	testing.						
	During the exit conference with the facility						
	Administrator and the Maintenance Supervisor on 08/31/23 at 3:29 p.m., no additional information or				how other residents having the	2	
					how other residents having the		
	evidence could be provided contrary to this			potential to be affected by the same deficient practice will be identified and what corrective			
	deficient finding.						
	deficient initing.				action(s) will be taken.		
	3.1-19(b)						
	5.2 5(4)						
	2) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99						
					All residents have the potentia	l to	
					be affected.		
		sting of the generator serving					
	the emergency electrical system to be in				p paraid="58298861"		

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

Event ID:

W0KD21 Facility ID: 000147 If continuation sheet Page 37 of 40

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
		155243	B. WING			08/31/2023	
NAME OF I			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER				300 WI	NDY HILL DR		
MAJEST	IC CARE OF LAFA	YETTE		LAFAY	ETTE, IN 47905		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG		DATE	
		FPA 110, the Standard for ndby Powers Systems, Chapter			paraeid="{29ab1a7c-9ae3-47	58-91	
					35-1be503fb10ee}{20}" >		
	8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a						
		nutes. Chapter 6.4.4.2 of NFPA			measures will be put into plac	_	
		n record of inspection,			and what systemic changes w		
	_	ising period, and repairs for the			be made to ensure that the		
	generator to be regularly maintained and available				deficient practice does not rec	cur.	
	for inspection by the authority having						
	jurisdiction. This deficient practice could affect all						
	occupants.						
	Findings include:				An annual fuel quality test for	the	
				diesel generator will be the			
					Maintenance Director or and t	he	
	Based on record review on 08/31/23 at 11:42 a.m.				results recorded.		
	with the Maintenance Supervisor, documentation						
	of Monthly testing of the facilities diesel-powered						
	generator was not available for review for January						
	1, 2023 through May 20, 2023. Based on an				All weekly generator inspection		
		e of record review, the		will be conducted and documented			
	Maintenance Supervisor confirmed that monthly				electronically in the current TE	-LS	
	generator testing did not occur during the			system weekly by the Maintenance Director or designee			
	aforementioned dates because the previous Maintenance Supervisor failed to conduct the				and documentation will be	Jnee	
				monitored for completion by			
	testing.			Administrator weekly to ensure			
	During the exit conference with the facility						
	Administrator and the Maintenance Supervisor on			the generator test was conducted weekly.			
	08/31/23 at 3:29 p.m., no additional information or				,		
	evidence could be provided contrary to this						
	deficient finding.						
					All monthly generator inspecti	ons	
	3.1-19(b)				will be conducted and docume		
	3) Based on record review and interview, the facility failed to exercise the generator annually to				electronically in the current TE	ELS	
					system monthly by the		
					Maintenance Director or design	gnee	
	•	nts of NFPA 110, 2010 Edition,			and documentation will be		
	the Standard for Emergency and Standby Powers				monitored for completion by		
	Systems, Chapter 8.4.2. Section 8.4.2 states diesel				Administrator monthly to ensu		
generator sets in service shall be exercised at least				the generator test was conduc	cted		

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155243		155243	B. WING 08/31/2023			/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
					NDY HILL DR		
MAJESTI	IC CARE OF LAFA	YEIIE		LAFAYI	ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	once monthly, for a	minimum of 30 minutes, using			weekly.		
	one of the following	g methods:			_		
	(1) Loading that ma	intains the minimum exhaust					
		recommended by the					
	manufacturer						
	(2) Under operating	temperature conditions and at					
	not less than 30 per	cent of the EPS (Emergency					
	Power Supply) nam	eplate kW rating.			ul class="BulletListStyle1		
	Section 8.4.2.3 state	es diesel-powered EPS			SCXW50707486 BCX8" role=	"list"	
	installations that do	not meet the requirements of			style="margin: 0px; padding: 0)px;	
	8.4.2 shall be exerc	ised monthly with the available			user-select: text;	• •	
	EPSS (Emergency Power Supply System) load and				-webkit-user-drag: none;		
	shall be exercised annually with supplemental				-webkit-tap-highlight-color:		
	loads (Load Bank Test) at not less than 50 percent				transparent; overflow: visible;		
	of the EPS nameplate kW rating for 30 continuous				cursor: text; font-family: verda	na;"	
	minutes and at not less than 75 percent of the EPS				how the corrective action(s) w		
	nameplate kW rating for 1 continuous hour for a				monitored to ensure the defici		
	total test duration of not less than 1.5 continuous				practice will not recur.		
	hours. This deficient practice could affect all						
	occupants.						
					All weekly generator inspectio	ns	
	Findings include:				will be conducted and docume		
					electronically in the current TE	ELS	
	Based on record rev	view on 08/31/23 at 11:44 a.m.			system weekly by the		
	with the Maintenan	ce Supervisor, the load			Maintenance Director or desig	inee	
	information to show the actual load percentage for				and documentation will be		
	the diesel-powered generator was not being			monitored for completion by			
	documented. Based on interview at the time of			Administrator weekly to ensure			
	record review, the Maintenance Supervisor			the generator test was conducted			
	acknowledged the generator ran under load on a				weekly.		
	weekly basis and did not achieve 30 % of the						
	name plate rating. Additionally, the Maintenance						
	Supervisor acknowledged a load bank test for the						
	generator had not occurred within the past				All monthly generator inspection	ons	
	twelve-month period.				will be conducted and docume		
	During the exit conference with the facility Administrator and the Maintenance Supervisor on				electronically in the current TE	LS	
					system monthly by the		
					Maintenance Director or desig	nee	
		n., no additional information or			and documentation will be		
	_	provided contrary to this			monitored for completion by		
1							1

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

Event ID:

 $W0KD21 \quad \ \ {\rm Facility\ ID:} \quad \ 000147$

If continuation sheet Page 39 of 40

PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-039

Page 40 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155243		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/31/2023			
NAME OF I	PROVIDER OR SUPPLIEF	- {			ADDRESS, CITY, STATE, ZIP COD			
MAJESTIC CARE OF LAFAYETTE			300 WINDY HILL DR LAFAYETTE, IN 47905					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG			COMPLETION DATE	
	deficient finding.				Administrator monthly to ensu	ıre		
	3.1-19(b)				the generator test was conductive weekly.	lucted		
	3.1-19(b) 4) Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review on 08/31/23 at 11:46 a.m. with the Maintenance Supervisor, there was no documentation of an annual fuel quality test for the diesel generator was available for review. Based on an interview at the time of record review, the Maintenance Supervisor confirmed that the annual fuel quality testing had not occurred because the previous Maintenance Supervisor failed to request the testing from the vendor. During the exit conference with the facility Administrator and the Maintenance Supervisor on 08/31/23 at 3:29 p.m., no additional information or evidence could be provided contrary to this deficient finding.				The annual fuel quality test for diesel generator will be review the QAA meeting and the next annual test will be scheduled the next calendar year. p="" paraid="1267933471" paraeid="{ee65ab1e-fc68-4d32-59a5b8c66f87}{118}">	ved in t for		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W0KD21 Facility ID: 000147 If continuation sheet