STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155243	A. BUILDING -- B. WING	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/31/23 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 At this Emergency Preparedness survey, Majestic Care of Lafayette was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 122 certified beds. At the time of the survey, the census was 86. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review completed on 09/07/23	E 0000	Majestic Care of Lafayette submits this POC as our credible allegation of compliance as of 09/29/23 and requests a desk review for compliance	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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

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	the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice			

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	per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise			

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

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

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

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

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

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	maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	p="" paraid="1097784388" paraeid="{47268172-2afa-4c9d-8a3f-ec171fac4e36}{216}"> p="" paraid="1097784388" paraeid="{677b1054-b894-4fa6-936f-fa9b917165a1}{200}">039 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; p="" paraid="1985904605" paraeid="{677b1054-b894-4fa6-936f-fa9b917165a1}{217}">An annual exercise led by the Maintenance Director or designee that includes a group discussion using a narrated, emergency scenario and a set a problem statements and prepared questions designed to challenge the emergency plan will	10/02/2023

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	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Supervisor on 08/31/23 at 12:50 p.m., the facility was unable to provide documentation of an annual full-scale exercise that is community-based, an annual individual, facility-based functional exercise, a second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Based on interview at the time of record review, the Maintenance Supervisor agreed that documentation of any of the aforementioned drills listed above were not available for review as of the time of this survey.		be scheduled was conducted on 09/28/23 and a second one scheduled to occur on or before 12/31/23. 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 to be affected. p="" paraid="801539566" paraeid="{677b1054-b894-4fa6-936f-fa9b917165a1}{254}"> what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: exercises will be pre-scheduled by the maintenance director or . The upcoming dates will be reviewed in the daily standup meeting with the interdisciplinary team on a weekly basis until they occur. p="" paraid="1831587151" paraeid="{9d84d1a4-91ee-43e8-b48c-06b59af70675}{44}"> Each month, the Maintenance director or will ensure that there a minimum of 2 facility exercises to test the emergency plan scheduled over the coming 12 months. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The scheduled dates and proper execution of the annual exercise	

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	During the exit conference with the facility Administrator and the Maintenance Supervisor on 08/31/23 at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.		will be reviewed in the QAA meeting to ensure: That there are always a minimum of 2 exercises planned on a rolling basis and that all scheduled exercises for that month are completed properly and according to the schedule. Missed exercises for the month will be promptly re-scheduled to occur within the next and before 12/31/23. p="" paraid="898912571" paraeid="{df1f3c3c-69f6-45f6-88fe-a99c7f94a9a7}{52}">	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety			

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(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
	Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING -- B. WING	08/31/2023

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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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	If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could	E 0041	p paraid="2859918" paraeid="{9d84d1a4-91ee-43e8-b48c-06b59af70675}{157}" >E041	09/29/2023

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	affect all occupants. 1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 28 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 08/31/23 at 11:40 a.m. with the Maintenance Supervisor, documentation for January 1, 2023 through May 22, 2023 along with 06/14/23, 06/21/23, and 06/28/23 weekly generator testing was not available for review. Based on an interview at the time of record review, the Maintenance Supervisor confirmed weekly generator testing did not occur during the aforementioned dates because the previous 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 evidence could be provided contrary to this deficient finding. 2) Based on record review and interview, the		what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; p paraid="219745348" paraeid="{9d84d1a4-91ee-43e8-b48c-06b59af70675}{174}" > The maintenance director will be educated on inspection of emergency power systems for the facility. 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; p paraid="1133102267" paraeid="{9d84d1a4-91ee-43e8-b48c-06b59af70675}{199}" >All residents have the potential to be affected. what measures will be put into place and what systemic changes will be made to ensure that the	

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	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 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 08/31/23 at 11:42 a.m. 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 interview at the time of record review, the Maintenance Supervisor confirmed that monthly generator testing did not occur during the aforementioned dates because the previous 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 evidence could be provided contrary to this deficient finding. 3) Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition,		deficient practice does not recur; All weekly generator inspections will be conducted and documented electronically in the current TELS system weekly by the Maintenance Director or designee and documentation will be monitored for completion by Administrator weekly to ensure the generator test was conducted weekly. All monthly generator inspections will be conducted and documented electronically in the current TELS system monthly by the Maintenance Director or designee and documentation will be monitored for completion by Administrator monthly to ensure the generator test was conducted weekly. p paraid="137243891" paraeid="{a40c7c8e-477e-4235-afa0-155e95c3785f}{21}" >	

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	the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on record review on 08/31/23 at 11:44 a.m. with the Maintenance Supervisor, the load information to show the actual load percentage for the diesel-powered generator was not being documented. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the generator ran under load on a 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 twelve-month period. During the exit conference with the facility		how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The weekly generator inspections logs in TELS will be reviewed in the monthly QAA meeting to ensure the inspections have been conducted each week per regulation. Any missed weekly generator inspections will be immediately will be provided to the Maintenance Director. The monthly generator inspections logs in TELS will be reviewed in the monthly QAA meeting to ensure the inspections have been conducted each month per regulation. Any missed monthly generator inspections will be immediately will be provided to the Maintenance Director. p="" paraid="2859918" paraeid="{df1f3c3c-69f6-45f6-88fe-a99c7f94a9a7}{81}">	

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	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. 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.			
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Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/31/23 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 At this Life Safety Code survey, Majestic Care of Lafayette 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 86 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for two detached storage garages which were used to store maintenance equipment, that were not sprinklered. Quality Review completed on 09/07/23	K 0000	Majestic Care of Lafayette submits this POC as our credible allegation of compliance as of 09/29/23 and requests a desk review for compliance	

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect as many as 6 staff if needing to exit the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on 08/31/23 at 2:15 p.m., the service hall corridor leading back to the kitchen area was totally obstructed by two cart warmers, four cart trays, and a 55-gallon trash container. Based on an interview at the time of the observation, the Maintenance Supervisor agreed that the corridor was obstructed and would cause a delay in egress during an emergency event necessitating the evacuation of the kitchen. 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. 3.1-19(b)	K 0211	p="" paraid="147850160" paraeid="{df1f3c3c-69f6-45f6-88fe-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: verdana;" what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The obstructions in the service hall corridor leading back to the kitchen were removed. how other residents having the potential to be affected by the	09/29/2023

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			same deficient practice will be identified and what corrective action(s) will be taken; p paraid="1383567855" paraeid="{a40c7c8e-477e-4235-afa0-155e95c3785f}{166}" > All residents have the potential to be affected. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The dietary manager, maintenance director or will ensure that obstructions in the service corridor leading to the kitchen area free from obstructions that would delay egress. The maintenance director and kitchen staff will be on the regulations regarding obstructions to egress and related safety issues that caused by them. The Maintenance Director or will	

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			monitor the service corridor 3 x weekly for obstructions that would create delayed egress and correct any findings immediately. p paraid="703955531" paraeid="{a40c7c8e-477e-4235-afa0-155e95c3785f}{231}" > how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The findings of weekly service corridor monitoring will be reviewed in the QAA meeting for 6 months. 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 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-b90e-f7640424f884}{88}" >	09/23/2023

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	to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 08/31/23 at 12:45 p.m. with the Maintenance Supervisor, there was no itemized list of resident rooms battery operated smoke alarms tested for functionality on a monthly basis for eleven of the last twelve months. Furthermore, there was no weekly preventative maintenance testing documentation as well. This was acknowledged by the Maintenance Supervisor at the time of record review. Based on observations during a tour of the facility with the Maintenance Supervisor, battery operated smoke alarms were observed in all resident sleeping rooms. 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. 3.1-19(b)		what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Maintenance Director will be educated on regulatory requirements of testing of smoke detectors as well as weekly preventative testing documentation. ul class="BulletListStyle1 SCXW183145791 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: verdana;" 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 to be affected. what measures will be put into place and what systemic changes will be made to ensure that the	

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			deficient practice does not recur; Monthly testing of all smoke alarms will be conducted and documented by the Maintenance Director or and recorded electronically into the existing TELS system. Weekly preventative testing of smoke alarms will be conducted by the Maintenance Director or and recorded electronically into the existing TELS system. ul class="BulletListStyle1 SCXW183145791 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: verdana;" how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The results of the monthly and weekly preventative testing of	

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			smoke detectors as recorded in the TELS system will be reviewed for timeliness and accuracy in the QAA meeting for 6 months.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler	K 0353	p paraid="1678069109" paraeid="{c5aaa1e7-d551-4c6f-b90e-f7640424f884}{244}" >K353 what corrective action(s) will be accomplished for those residents found to have been affected by the	09/29/2023

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(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
	systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the facility's sprinkler vendor report "Sprinkler: Report of Inspection" documentation for the most recent twelve-month period with the Maintenance Supervisor during record review at 11:15 a.m. on 08/31/23, weekly dry sprinkler system gauge inspection documentation for 33 weeks of the most recent 52-week period was not available for review. Monthly wet sprinkler system gauge inspection documentation for four months of the most recent twelve-month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 4 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. During the exit conference with the facility Administrator and the Maintenance Supervisor on		deficient practice; The Maintenance Director will be educated on regulatory requirements regarding weekly dry gauge inspections as well as monthly inspection documentation for all wet sprinkler system gauges and monthly inspection of all sprinkler system control valves. p paraid="418888906" paraeid="{c90da9cd-3c77-4cd3-bec1-873f7d6c7606}{58}" > 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 to be affected. ul class="BulletListStyle1 SCXW117463394 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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	08/31/23 at 3:29 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		transparent; overflow: visible; cursor: text; font-family: verdana;" what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director or will conduct weekly dry sprinkler gauge inspection and record them in the existing TELS system. The Maintenance Director or designee will conduct monthly inspections of all wet sprinkler system gauges as well as monthly inspections of all sprinkler system control valves and record the existing TELS system how the corrective action(s) will be monitored to ensure the deficient practice will not recur The results of the weekly dry sprinkler gauge inspections, the monthly inspections of the wet sprinkler system gauges and monthly inspection of all sprinkler system control valves will be reviewed for timeliness and accuracy in the QAA meeting for 6 months.	

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	155243	A. BUILDING 01 B. WING	08/31/2023

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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

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K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke 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 failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that 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 only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 16 residents, 3 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on 08/31/23 at 1:45 p.m., the set of smoke barrier doors nearest to the Medical Records office had a one-inch gap along the center where the doors came together in the closed position. This was verified by the Maintenance Director at the time of observation who added that he had worked on	K 0374	K374 p paraid="1013275627" paraeid="{c90da9cd-3c77-4cd3-bec1-873f7d6c7606}{191}" > what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The gap along occurring in the set of smoke barrier doors nearest to the Medical Records office was corrected. ul class="BulletListStyle1	09/29/2023

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	these doors before and would get them to fully close as soon as possible. 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. 3.1-19(b)		SCXW187053149 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: verdana;" 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 to be affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. p paraid="1969039579" paraeid="{717a9229-7a7e-4aaf-b617-2c0115e55ca2}{5}" > The Maintenance Director or will conduct monthly inspections of the fire doors for proper functioning and log the result. the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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			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-b617-2c0115e55ca2}{70}" > what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	09/29/2023

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	2023 on the third shift or a second quarter (April, May, and June) fire drill for 2023 on the first, second, or third shifts in 2023. Based on interview at the time of record review, the Maintenance Supervisor acknowledged that there was no additional fire drill documentation available for review at the time of this survey. 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. 3.1-19(b) 3.1-51(c)		The Maintenance Director will be educated on the regulatory for the proper conducting of fire drills. ul class="BulletListStyle1 SCXW158247595 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: verdana;" 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 to be affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. p paraid="1861668446" paraeid="{717a9229-7a7e-4aaf-b617-2c0115e55ca2}{125}" > The Maintenance director or will conduct fire drills in accordance	

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			with the regulatory requirements and record the results. how the corrective action(s) will be monitored to ensure the deficient practice will not recur. The results of documented fire drills will be reviewed for timeliness, accuracy and content in the QAA meeting for 6 months.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or			

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	renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure 588 of 588 electrical receptacles were tested in resident sleeping rooms. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 gram (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 08/31/23 at 11:37 a.m. with the Maintenance Supervisor, there was no receptacle retention testing documentation to test the physical integrity, continuity, or polarity of the resident room receptacles available for review. Based on observations made during a tour of the facility, the facility's 84 resident rooms had roughly 7 electrical receptacles in each room, and they were not hospital grade outlets. Based on interview at the time of the observation and	K 0914	p paraid="1885075600" paraeid="{0aa425de-3f2b-4630-9c30-a8d798a48f73}{37}" >K914 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. p paraid="1305108723" paraeid="{0aa425de-3f2b-4630-9c30-a8d798a48f73}{54}" > The Maintenance Director will be 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.	09/29/2023

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	records review, the Maintenance Supervisor stated there was no documentation of testing per NFPA 99, Receptacle Testing requirements because the previous Maintenance Supervisor failed to conduct the testing. 3.1-19(b)		p paraid="856208392" paraeid="{0aa425de-3f2b-4630-9c30-a8d798a48f73}{85}" >All residents have the potential to be affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Receptacle testing in all resident rooms will be conducted by the maintenance director or designee to ensure all receptacles are visually inspected, verification of the continuity of the grounding circuit, correct polarity of the hot and neutral connections confirmed and retention force of the grounding blade for each receptacle is checked. p paraid="1259794289" paraeid="{0aa425de-3f2b-4630-9c30-a8d798a48f73}{130}" > The results of all receptacle testing will be recorded in TELS and reviewed weekly in the morning stand-up meeting with the	

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			interdisciplinary team how the corrective action(s) will be monitored to ensure the deficient practice will not recur. The results of the receptacle testing will be reviewed in the monthly QAA meeting to ensure they are completed in their entirety. Any areas with receptacles noted not to be tested will be scheduled for immediate testing and reviewed again in the next QAA until all receptacles are tested and verified to be functional in so far as they have been visually inspected, verified for the continuity of the grounding circuit, tested for the correct polarity of the hot and neutral connections and retention force of the grounding blade for each receptacle is verified and all are functional. p="" paraid="72163351" paraeid="{717a9229-7a7e-4aaf-b617-2c0115e55ca2}{245}">	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric			

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	System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 28 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with	K 0918	p="" paraid="2088163203" paraeid="{ee65ab1e-fc68-4d31-a9d2-59a5b8c66f87}{39}"> p paraid="2088163203" paraeid="{0aa425de-3f2b-4630-9c3	09/29/2023

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	NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 08/31/23 at 11:40 a.m. with the Maintenance Supervisor, documentation for January 1, 2023 through May 22, 2023 along with 06/14/23, 06/21/23, and 06/28/23 weekly generator testing was not available for review. Based on an interview at the time of record review, the Maintenance Supervisor confirmed weekly generator testing did not occur during the aforementioned dates because the previous 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 evidence could be provided contrary to this deficient finding. 3.1-19(b) 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 requires monthly testing of the generator serving the emergency electrical system to be in		0-a8d798a48f73}{219}" >K918 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. p paraid="88729463" paraeid="{0aa425de-3f2b-4630-9c3 0-a8d798a48f73}{240}" >The Maintenance Director will be educated on the regulatory for weekly generator inspections, monthly generator tests and annual fuel quality testing for the diesel generator. 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 to be affected. p paraid="58298861"	

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	accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 08/31/23 at 11:42 a.m. 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 interview at the time of record review, the Maintenance Supervisor confirmed that monthly generator testing did not occur during the aforementioned dates because the previous 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 evidence could be provided contrary to this deficient finding. 3.1-19(b) 3) Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least		paraeid="{29ab1a7c-9ae3-4758-9135-1be503fb10ee}{20}" > measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. An annual fuel quality test for the diesel generator will be the Maintenance Director or and the results recorded. All weekly generator inspections will be conducted and documented electronically in the current TELS system weekly by the Maintenance Director or designee and documentation will be monitored for completion by Administrator weekly to ensure the generator test was conducted weekly. All monthly generator inspections will be conducted and documented electronically in the current TELS system monthly by the Maintenance Director or designee and documentation will be monitored for completion by Administrator monthly to ensure the generator test was conducted	

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MAJESTIC CARE OF LAFAYETTE	300 WINDY HILL DR 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
	once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on record review on 08/31/23 at 11:44 a.m. with the Maintenance Supervisor, the load information to show the actual load percentage for the diesel-powered generator was not being documented. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the generator ran under load on a 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 twelve-month period. 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		weekly. ul class="BulletListStyle1 SCXW50707486 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: verdana;" how the corrective action(s) will be monitored to ensure the deficient practice will not recur. All weekly generator inspections will be conducted and documented electronically in the current TELS system weekly by the Maintenance Director or designee and documentation will be monitored for completion by Administrator weekly to ensure the generator test was conducted weekly. All monthly generator inspections will be conducted and documented electronically in the current TELS system monthly by the Maintenance Director or designee and documentation will be monitored for completion by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 01 B. WING	08/31/2023

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	deficient finding. 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. 3.1-19(b)		Administrator monthly to ensure the generator test was conducted weekly. The annual fuel quality test for the diesel generator will be reviewed in the QAA meeting and the next annual test will be scheduled for the next calendar year. p="" paraid="1267933471" paraeid="{ee65ab1e-fc68-4d31-a9d2-59a5b8c66f87}{118}">	