STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155689	A. BUILDING -- B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/01/23 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this Emergency Preparedness survey, Majestic Care of Goshen was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 186 certified beds. At the time of the survey, the census was 132. Quality Review completed on 02/06/23	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caley Nixon	Executive Director	02/17/2023

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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	preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	#1.) Based on record review and interview, it could not be assured the facility maintained an Emergency Preparedness Plan (EPP) that was	E 0004	**E004 – Develop EP Plan, Review and Update Annually** It is the practice of this facility to	02/17/2023

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	specific to the facility in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 10:00 a.m., the facility provided two different EPPs with conflicting information. The first EPP provided was a generic plan with no building specific information. The second EPP provided did address some but not all the current information for Majestic Care. Based on an interview during records review, the Maintenance Director agreed there were two different EPPs in the facility. #2.) Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Assistant Director of Nursing on 02/01/23 at 10:01 a.m., the provided EPP did not have documentation of when the EPP was last reviewed. There was a form provided dated 01/13/23 with signatures without job titles that stated "The IDT team at Majestic Care of Goshen has reviewed and updated all policies for 2022 through 2023" but the form did not specifically say the EPP was reviewed and updated. Additionally based on record review, it could not be assured all policies and procedures had been updated due to the lack of a documented risk assessment, lack of resident & staff tracking policy, shelter-in-place policy, use of volunteer		maintain an Emergency Preparedness Plan that is specific to the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Emergency Preparedness Plan has been updated to reflect facility specific policies and procedures, education has been provided to all staff, and scheduled review dates have been implemented. **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 by this deficient practice. The Emergency Preparedness Plan has been updated to reflect facility specific policies and procedures, education has been provided to all staff, and scheduled review dates have been implemented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will	

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	policy and various other policies. Based on an interview during records review, the Maintenance Director stated it was unknown when the EPP specifically has been reviewed and updated. The findings were reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		include a review of the Emergency Preparedness Plan. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0006 SS=F	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2),			

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

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	(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included	E 0006	**E006 – Plan Based on All Hazards Risk Assessment** It is the practice of this facility to maintain an Emergency Preparedness Plan that is based on and includes a documented,	02/17/2023

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	strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 10:06 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on interview at the time of record review, the Maintenance Director stated he has a risk assessment form but was not completed. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		facility-based, and community-based risk assessment, utilizing all-hazards approach using events identified by the risk assessment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Risk assessment has been reviewed and updated to reflect facility specific information. **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 by this deficient practice. The Risk Assessment has been reviewed and updated to reflect facility specific information. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan and Risk Assessment. The Executive Director/Designee will audit the Emergency Preparedness Plan	

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			monthly during QAPI to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b),			

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	§483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and			

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	nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Assistant Director of Nursing on 02/01/23 at 10:01 a.m., the provided EPP did not have documentation of when the EPP Policies and Procedures were last reviewed. There was a form provided dated 01/13/23 with signatures without job titles that stated "The IDT team at Majestic	E 0013	**E013 – Development of EP Policies and Procedures** It is the practice of this facility to review and update the Emergency Preparedness Plan, Policies, and Procedures at least annually. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Emergency Preparedness Plan, Policies, and Procedures have been reviewed and updated and all staff have been educated.	02/17/2023

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	Care of Goshen has reviewed and updated all policies for 2022 through 2023" but the form did not specifically say the EPP was reviewed and updated. Based on an interview during records review, the Maintenance Director stated it was unknown when the EPP Policies and Procedures have been reviewed and updated. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		**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 by this deficient practice. The Emergency Preparedness Plan, Policies, and Procedures have been reviewed and updated and all staff have been educated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:**	

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			Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If			

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	155689	A. BUILDING -- B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants, Findings include:	E 0018	**E018 – Procedures for Tracking of Staff and Patients** It is the practice of this facility to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/17/2023

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	Based on records review with the Maintenance Director on 02/01/23 at 10:30 a.m., the reviewed EPP did not have a policy and procedure that includes a system to track the location of residents and staff during and after an emergency. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain a staff and resident tracking policy. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		**practice:** Policy for tracking residents and staff was reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy for tracking of residents and staff was reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0022 SS=F Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities]			

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	must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 10:30 a.m., the reviewed EPP did not have a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the LTC	E 0022	**E022 – Policies/Procedures for Sheltering in Place** It is the practice of this facility to ensure the emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	02/17/2023

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	facility. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain a shelter in place policy. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		The policy related to sheltering in place for residents, staff, and volunteers has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy for sheltering in place for residents, staff, and volunteers has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).			

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	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure Emergency Preparedness Plan (EPP) includes the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of	E 0024	**E024 - Policies/Procedures – Volunteers and Staffing** It is the practice of this facility to ensure the Emergency Preparedness Plan includes the	02/17/2023

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	State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 10:40 a.m., the reviewed EPP did not have a policy on the use of volunteers in an emergency. Based on interview during records review, the Maintenance Director stated a policy on the use of volunteers in an emergency could not be found. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		use of volunteers in an emergency or other emergency staffing strategies. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to volunteers and staffing has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to volunteers and staffing has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the	

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			Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0026 SS=F Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C) (iv), 441.184(b)(8), 482.15(b)(8), 483.475(b) (8), 483.73(b)(8), 485.625(b)(8), 485.920(b)			

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	(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site	E 0026	**E026- Roles Under a Waiver Declared by Secretary** It is the practice of this facility to ensure the Emergency Preparedness Plan includes the roles of the LTC facility under a	02/17/2023

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	identified by emergency management officials in accordance with 42 CFR 483.73(b) (8). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:11 a.m., the reviewed EPP did not have a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain the 1135 waiver policy. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		waiver declared by the Secretary. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to the roles of the LTC facility under a waiver been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to the roles of the LTC facility under a waiver has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan	

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			monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan			

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	§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Assistant Director of Nursing on 02/01/23 at 10:01 a.m., the provided EPP did not have documentation of when the EPP Communication Plan was last reviewed. There was a form provided dated 01/13/23 with signatures without job titles that stated "The IDT team at Majestic Care of Goshen has reviewed and updated all policies for 2022 through 2023" but the form did not specifically say the EPP was reviewed and updated. Based on an interview during records review, the Maintenance Director stated it was unknown when the EPP Communication Plan has been reviewed and updated. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director	E 0029	**E029 – Development of Communication Plan** It is the practice of this facility to ensure the Emergency Preparedness Plan communication plan is reviewed and updated at least annually. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to communication has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to communication has been reviewed	02/17/2023

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	155689	A. BUILDING -- B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	during the exit conference.		and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an	

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			action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following:			

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	(i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) communication plan included contact information for all the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:17 a.m., the reviewed EPP communication plan was missing the contact information for The Office of the State Long-Term Care Ombudsman. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain contact information for the State Ombudsman.	E 0031	**E031 – Emergency Officials Contact Information** It is the practice of this facility to ensure the Emergency Preparedness Plan communication plan includes the contact information for The Office of the State Long-Term Care Ombudsman. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to communication has been reviewed and updated to include the appropriate contact information to be included in the Emergency Preparedness Plan. **How other residents having the**	02/17/2023

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	This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		**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 by this deficient practice. The policy related to communication has been reviewed and updated to include the appropriate contact information to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this	

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			corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023 **E032 – Primary/Alternate Means for Communication** It is the practice of this facility to ensure the Emergency Preparedness Plan includes the communication plan for primary and alternate means for communication for; LTC facility staff, Federal, State, tribal, regional, or local emergency management agencies. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to	

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			communication has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to communication has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0032 SS=C Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain			

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	an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:33 a.m., the reviewed EPP did not address the primary and alternate means for communication during an emergency. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did address the primary and alternate means for communication. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director	E 0032	**E032 – Primary/Alternate Means for Communication** It is the practice of this facility to ensure the Emergency Preparedness Plan includes the communication plan for primary and alternate means for communication for; LTC facility staff, Federal, State, tribal, regional, or local emergency management agencies. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to communication has been reviewed and updated to be included in the Emergency Preparedness Plan.	02/17/2023

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	during the exit conference.		**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 by this deficient practice. The policy related to communication has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored	

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			though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0033 SS=C Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated			

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	at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility failed to ensure the emergency preparedness (EPP) communication plan includes (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care	E 0033	**E033 – Methods for Sharing Information** It is the practice of this facility to ensure the Emergency Preparedness Plan communication plan includes a	02/17/2023

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	providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.73(c)(4). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:32 a.m., the reviewed EPP communication plan did not include a method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain a method for sharing information policy. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		method for sharing information and medical documentation for residents under the LTC facility care, a means for release of information during an evacuation, and a means of providing information about the general condition and location of residents under the facilities care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to communication has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to communication has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive	

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			Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	

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	155689	A. BUILDING -- B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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E 0034 SS=C Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident			

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	Command Center, or designee. Based on record review and interview, the facility failed to ensure the emergency preparedness (EPP) communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:34 a.m., the reviewed EPP communication plan did not address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain a plan that address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.	E 0034	**E034 – Information on Occupancy/Needs** It is the practice of this facility to ensure the Emergency Preparedness Plan communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to occupancy/needs has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to occupancy/needs has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	02/17/2023

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			practice does not recur: All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic**	

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			changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness (EEP) communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants.	E 0035	**E035 – LTC and ICF/IID Sharing Plan with Patients** It is the practice of this facility to ensure the Emergency Preparedness Plan communication plan includes a method for sharing information from the emergency plan that the facility has determine is	02/17/2023

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	Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:39 a.m., the reviewed EPP communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain a plan that discussed a method for sharing information from the emergency plan deemed appropriate with residents and their families or representatives. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		appropriate with residents and their families or representatives. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to communication; including a method for sharing information has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to communication; including a method for sharing information has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and	

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			Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d),			

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	485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least			

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	annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness (EPP) training and testing program that is based on the emergency plan accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance	E 0036	**E036 – EP Training and Testing** It is the practice of this facility to ensure the Emergency Preparedness Plan includes a training and testing program that is based on the emergency plan. **What corrective action(s) will be accomplished for those residents found to have been**	02/17/2023

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	Director on 02/01/23 at 10:30 a.m., the reviewed EPP table of contents listed the training program in section T. Section T was titled Emergency Preparedness Training and Testing, but the rest of the page was blank. Based on interview during records review, the Maintenance Director agreed the reviewed EPP training program policy page was left blank. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		**affected by the deficient practice:** The policy related to emergency preparedness training and testing has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to emergency preparedness training and testing has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate.	

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			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: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1),			

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	§491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out			

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

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	emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include			

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	instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of			

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	emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director and Assistant Director of Nursing on 02/01/23 at 11:55 a.m., no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Assistant Director of Nursing stated training was conducted by use of a computer training program but was unable to print or show the EPP training documentation. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.	E 0037	**E037 – EP Training Program** It is the practice of this facility to ensure that annual training is conducted to review the Emergency Preparedness Plan. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to emergency preparedness training and testing has been reviewed and updated to be included in the Emergency Preparedness Plan. **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 by this deficient practice. The policy related to emergency preparedness training and testing has been reviewed and updated to be included in the Emergency Preparedness Plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service	02/17/2023

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			will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	

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E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)			

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	(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 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			

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	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 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			

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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 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

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	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, 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.			

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	(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. (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			

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	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 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]			

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	(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 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			

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	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 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 an additional exercise of choice to test the emergency plan at least twice per year. The LTC facility must do the following:	E 0039	**E039 – EP Testing Requirements** It is the practice of this facility to participate in an annual full-scale	02/17/2023

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	(i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility 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: 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 with the Maintenance Director on 02/01/23 at 9:54 a.m., there was community drill with the fire department in September of 2022, but documentation of an additional annual exercise of choice within the last year was not available for review. Based on interview at the time of records review, the		exercise that is community based, a mock disaster drill, or tabletop exercise designed to challenge the Emergency Preparedness Plan. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy related to emergency preparedness training and testing has been reviewed and updated to be included in the Emergency Preparedness Plan. An additional table top drill was executed and reviewed with the entire team. **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 by this deficient practice. The policy related to emergency preparedness training and testing has been reviewed and updated to be included in the Emergency Preparedness Plan. The facility will plan dates for participation for all annual exercises. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	155689	A. BUILDING -- B. WING	02/01/2023

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	Maintenance Director stated an additional annual exercise of choice was not conducted within the last 12 months. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures; including the requirement for annual full-scale exercises. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually; this review will ensure that scheduled annual full-scale exercises are followed through. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance	

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			Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2)			

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	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. 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,			

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	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 records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 at 10:30 a.m., the facility failed to maintain the two (2) Emergency Generators by ensuring proper testing and documentation	E 0041	**E041 – Hospital CAH and LTC Emergency Power** It is the practice of this facility to ensure emergency generators are properly tested and documented as required by LSC and NFPA. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility generators have been	02/17/2023

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	required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director agreed both generators were missing proper documentation and some required testing. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		placed on weekly testing that require documentation. **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 by this deficient practice. The policy related to generator testing and documentation has been reviewed and updated to be included in the Emergency Preparedness Plan. Generator testing and documentation has been placed on weekly TELS task list for completion by the Maintenance Director/Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff be in-serviced on or before 2/17/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of the Emergency Preparedness Plan, Policies, and Procedures related to generator testing and documentation. The Executive Director/Designee will audit the TELS monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed	

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			and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI "TELS" weekly for 4 weeks and monthly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 02/01/23 Facility Number: 000091	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these**	

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	Provider Number: 155689 AIM Number: 100290080 At this Life Safety Code survey, Majestic Care of Goshen 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) and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered with the exception of the spce behid the dryers. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The building is partially protected by two 200 kW natural gas powered emergency generators. The facility has a capacity of 186 and had a census of 137 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was not sprinklered and two detached, garage sized storage sheds used for storage by the facility that were not sprinklered. Quality Review completed on 02/06/23		**findings we respectfully request a desk review in lieu of a traditional revisit.**	
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			

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	through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 12 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could 30 residents in the Cedar Wing. Findings include: Based on observations with the Maintenance Director on 02/01/23 at 12:33 p.m., the Cedar Wing dining room exit door was equipped with panic hardware, but the door would not open on the first try. It took the Maintenance Director three tries to open the door and took excessive force to open the door on the fourth try. Based on interview at the time of observation, the Maintenance Director stated the door is sticking on the frame and will need to be adjusted. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	**K211 – Means of Egress – General** It is the practice of this facility to ensure exit discharge doors are free of impediments to full instant use in the case of fire or other emergency. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Cedar Wing dining room exit door was adjusted to ensure the door opens immediately when pressed. **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 residing on Cedar Wing have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	02/17/2023

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			practice does not recur: All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of means of egress. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be**	

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			completed: 02/17/2023 Compliance Date = 02/17/2023	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors			

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	upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and Interview, the facility failed to ensure 2 of 10 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf	K 0222	**K222 – Egress Doors** It is the practice of this facility to ensure all delayed egress locking arrangements are installed and functioning properly. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	02/17/2023

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	(67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 30 residents and staff in the Main Dining and 300 hall area Findings include: Based on observation during a tour of the facility with the Maintenance Director and House Keeping Director on 02/01/23 between 12:00 p.m. and 2:45 p.m., the following was noted: a) The exit door in the Main Dining area was equipped with 15 second delay egress arrangements. When tested, it took 3 tries to activate the delayed egress function. b) The exit door near room 317 had delayed egress installed. The delayed egress did not activate on the first and third try, the second try activated the function, but took longer than 15 seconds. The findings were reviewed with the Maintenance Director and Assistant Director of Nursing during the exit conference. 3.1-19(b)		A) The exit door in the Main Dining has been adjusted and is functioning properly. B) The exit door near room 317 has been adjusted and is functioning properly. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of egress doors. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months.	

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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
			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: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5			

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	Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 3 corridors in Cedar Wing or met an exception per LSC 19.2.3.4(5) which states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 40 residents Cedar Wing. Findings include: Based on observation with the Maintenance	K 0232	**K232 – Aisle, Corridor, or Ramp Width** It is the practice of this facility to ensure clear width is met for all corridors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A. The chairs in the corridor by the Cedar nurses station were removed and staff educated on corridor width requirements. B. The recliners stored in the annex exit corridor have been removed and staff have been educated on corridor width requirements. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	02/17/2023

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	Director on 02/01/23 at 1:04 p.m., there were three chairs in the corridor by the Cedar nurses station extending about two-feet into the eight-foot corridor and were not affixed to the floor or to the wall when tested. Also, the Cedar annex exit corridor had 8 recliners stored in the hall obstructing the corridor by 4 feet. Based on interview at the time of the observations, the Maintenance Director agreed the chairs were not securely attached to the floor or to the wall when tested and recliners are being stored in a exit corridor. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		**practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of means of egress and corridor width requirements. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic**	

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			changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking	K 0324	**K324 – Cooking Facilities** It is the practice of this facility to ensure staff have access to necessary shutoff switches. **What corrective action(s) will be accomplished for those**	02/17/2023

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	facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym. Findings include: Based on observation with the Maintenance Director on 02/01/23 at 2:14 p.m., there was a cooktop in the therapy gym that was separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance Director stated no, staff do not have access to disconnect power to the stove. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice:** Contractors have been scheduled to install switch for staff access to necessary shut off for the cooktop in the therapy gym. **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 in the therapy gym have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of shut off switches; location and use as neccessary. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month,	

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			2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be			

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	evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on observation with the Maintenance Director on 02/01/23 at 10:24 a.m., the fire watch plan stated to contact the department of health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Also, the fire watch plan stated to contact the fire department, insurance carrier, facility operator, and mongering company but the space to list phone numbers was blank. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the department of health but not via the IDOH Gateway link or at the e-mail address listed above and the other contacts were left blank. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.	K 0346	**K346 – Fire Alarm System – Out of Service** It is the practice of this facility to ensure a policy is provided for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four hour period. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The fire watch policy has been updated to include contacting the Indiana Department of Health via the IDOH Gateway link or by secondary method as well as contact updates to all local fire departments, insurance carriers, and facility operator. **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 by this deficient practice. The policy related to the protection of residents indicating procedures to be followed in the	02/17/2023

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	3.1-19(b)		event the fire alarm system has to be placed out of service for four hours or more in a twenty-four hour period has been reviewed, updated, and included in the emergency preparedness plan and all staff have been educated on policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of fire watch policy and reporting requirements. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	

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			Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler			

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	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 5 smoke compartments. This deficient practice could affect 10 staff. Findings include: Based on observation on 02/01/23 between 12:00 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Director and House Keeping Manager, in the laundry room there was a room behind three dryers which were gas powered. No sprinkler head could be located inside of the room at the time of observation. Based on interview at the time of observation, the Maintenance Director acknowledged a sprinkler head could not be seen and could not confirm if there was sprinkler coverage in the room. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director at the exit conference. 3.1-19(b)	K 0351	**K351 – Sprinkler System – Installation** It is the practice of this facility to provide an automatic sprinkler system that covers all smoke compartments. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents have the potential to be affected by this deficient practice. Vendor contacted to install sprinkler heads behind dryers in laundry room. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	02/17/2023

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			practice does not recur: The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	

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K 0352 SS=E Bldg. 01	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility failed to maintain monitoring of 1 of 1 mechanical penthouse sprinkler system in accordance with LSC 9.7.2.1. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice affects staff and 15 residents in below the mechanical penthouse. Findings include: Based on observation with the Maintenance Director on 02/01/23 at 10:14 a.m., in the maintenance office there was a control valve on	K 0352	**K352 – Sprinkler System – Supervisory Signals** It is the practice of this facility to maintain monitoring of all mechanical penthouse sprinkler systems. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Vendor has been contacted to repair wire control valve for sprinkler line in maintenance office. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds”	02/17/2023

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	the sprinkler line that went to the sprinklers in the mechanical penthouse. The valve had an electrical monitoring box, but wires were hanging from the box and not hooked up to anything. Based on interview at the time observation, the Maintenance Director agreed the valve controlled the sprinklers in the mechanical penthouse and was not electronically supervised by the fire alarm system. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be	

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	155689	A. BUILDING 01 B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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
			submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
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 #1.) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and	K 0353	**K353 – Sprinkler Systems – Maintenance and Testing** It is the practice of this facility to maintain sprinkler systems and ensure all automatic sprinkler systems shall be inspected and maintained. **What corrective action(s) will**	02/17/2023

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	testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/01/23 between 09:45 a.m. and 12:00 p.m., there was no monthly inspection of the wet pipe sprinkler system's gauges and valves for the past 12 months. Checks shown from the "TELS" program, checks were documented as "N/A". During an interview at the time of record review, the Maintenance Director stated the inspections of gauges and valves are conducted monthly, but could not upload documentation for confirmation. #2.) Based on observation and interview, the facility failed to ensure 12 of 45 sprinkler heads of the exterior eaves, 3 of 5 sprinkler heads in laundry, and 1 of 2 sprinkler heads in room 125 were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice		**be accomplished for those residents found to have been affected by the deficient practice:** 1) All sprinklers have been placed on a monthly inspection and documentation schedule in TELS. 2) All sprinkler heads have been inspected and cleaned and needed. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of egress doors. The Maintenance Director/Designee will be responsible for completing QAPI	

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	could affect all staff and residents Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/01/23 between 12:00 p.m. and 2:45 p.m. the following sprinkler heads were covered in dust or showed signs of loading, a) 12 sprinkler heads under the eaves on the outside of Birch Wing and Dogwood Wing were loaded with dirt and other foreign material b) Three sprinkler heads in the laundry room near the dryers were covered with dust and lint. c) One sprinkler head in the closet of room 125 had red fabric attached to the deflector plate. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading. Findings were discussed with the Assistant Director of Nursing and Maintenance Director at exit conference. 3.1-19(b)		audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service			

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	Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include:	K 0354	**K354 – Sprinkler System – Out of Service** It is the practice of this facility to ensure a policy is provided for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four hour period. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The fire watch policy has been updated to include contacting the Indiana Department of Health via the IDOH Gateway link or by secondary method as well as contact updates to all local fire departments, insurance carriers, and facility operator.	02/17/2023

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	Based on observation with the Maintenance Director on 02/01/23 at 10:24 a.m., the fire watch plan stated to contact the department of health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Also, the fire watch plan stated to contact the fire department, insurance carrier, facility operator, and mongering company but the space to list phone numbers was blank. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the department of health but not via the IDOH Gateway link or at the e-mail address listed above and the other contacts were left blank. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		**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 by this deficient practice. The policy related to the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four hour period has been reviewed, updated, and included in the emergency preparedness plan and all staff have been educated on policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of fire watch policy and reporting requirements. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annually to ensure compliance is maintained and policies/procedures are reviewed and updated as appropriate. **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke			

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	compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 1 doors to the corridor would completely resist the passage of smoke. This deficient practice could affect approximately 15 residents and staff. Findings include:	K 0363	**K363 – Corridor - Doors** It is the practice of this facility to all doors to the corridor completely resist the passage of smoke. **What corrective action(s) will be accomplished for those**	02/17/2023

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	Based on observation during a tour of the facility on 02/01/23 between 12:00 p.m. and 2:45 p.m. with the House Keeping Manager, the door to room 126 had a one-half inch half-moon shaped hole above the handle to the door that opened to the corridor. This was acknowledged by the House Keeping Manager at the time of observation. Findings were discussed with the Assistant Director of Nursing and the Maintenance Director at exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice:** 1. Door to room 126 hole was appropriately filled and fixed to ensure the resistance of passage of smoke. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months which will ensure the checking of doors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
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			

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	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 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the House Keeping Manager on 02/01/23 between 12:00 p.m. and 2:45 p.m., the sets of smoke barrier doors in the Birch Wing near room 125 would not fully close when tested three times. When tested, the door would rub up against the top of the frame and would stop the door from fully closing. This condition creates a one-half inch gap between the doors when shut. Based on interview during the time of observations, the House Keeping Manager agreed that the smoke doors would not close when tested. The finding was reviewed with the Maintenance Director and the Assistant Director of Nursing during the exit conference. 3.1-19(b)	K 0374	**K374 – Subdivision of Building Spaces – Smoke Barrier** It is the practice of this facility to maintain sprinkler systems and ensure all automatic sprinkler systems shall be inspected and maintained. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. Set of smoke barrier doors in the Birch Wing were adjusted to ensure they fully close when tested. **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 residing on Birch Wing have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months.	02/17/2023

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023**	

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K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 2 of 22 fire dampers in the facility were repaired after inspection in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.2.3.3 states unobstructed access shall be provided through the ceiling or wall to gain access for inspection and service of the damper's working parts. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on records review with the Maintenance Director on 02/01/23 between 9:45 a.m. and 12:00 p.m., the Fire Damper Inspection Checklist dated 10/19/23 indicated two fire dampers listed 206 and 207 could not be inspected due to not having access parts and listed "need to install access parts." No other documentation was provided to show if the two dampers were fixed or re-inspected. Based on interview at the time of	K 0521	**K521 - HVAC** It is the practice of this facility to ensure the fire dampers in the facility are repaired after inspection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Vendor was contacted for additional fire damper inspection and supporting documentation on previous fire damper inspections provided. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for ensuring damper inspections are properly scheduled and documented	02/17/2023

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	records review, the Maintenance Director confirmed there were dampers on the inspection form that needed repair and stated there no other documentation could be found to show if the repairs were made. The finding was reviewed with the Assistant Director of Nursing and Maintenance Director at the exit conference. 3.1-19(b)		through TELS. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months to include TELS review. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	

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			By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on interview and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants.	K 0711	**K711 – Evacuation and Relocation Plan** It is the practice of this facility to ensure the fire safety plan contains information on evacuation of smoke compartments including addressed and locations of smoke/fire barriers. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The policy and facility map related to fire safety plan including the evacuation of smoke	02/17/2023

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	Findings include: Based on records review with the Maintenance Director on 02/01/23 at 11:14 a.m., the provided fire safety plan contained information on evacuation of smoke compartments but did not address the locations of smoke/fire barriers. Based on interview during records review, the Maintenance Director stated no documentation was available to show were all smoke/fire barriers were located. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		compartments was reviewed and updated to be included in the emergency preparedness plan. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly during QAPI to ensure policies remain up to date. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of fire safety plan including evacuation and communication. The Maintenance Director/Designee will be responsible for reviewing the Emergency Operations Plan monthly during QAPI to ensure policies remain up to date. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for reviewing the Emergency Operations plan monthly during QAPI and updating as needed. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 staff smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices and ensured that smoking took place in the designated smoking area. This deficient practice could affect staff in the service hall and kitchen. Findings include: Based on observation with the Maintenance Director and House Keeping Manager on 02/01/23 between 10:00 a.m. and 2:00 p.m., the following was observed: a) In the staff smoking area there were 20 plus cigarette butts on the ground. b) By the service hall exit (a no smoking area) were 20 plus cigarette butts on the ground. c) Around the corner by the service hall exit (a no smoking area) there was a metal can without a lid filled with cigarette butts. d) Outside of the kitchen exit (a no smoking area) were 20 plus cigarette butts on the ground. Based on interview at the time of observations,	K 0741	**K741 – Smoking Regulations** It is the practice of this facility to ensure staff smoking areas are maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices and ensuring that smoking is taking place in designated smoking area. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a. All cigarette butts were cleaned up around the staff smoking area. b. All cigarette butts were cleaned up around the service hall exit. c. The metal can near the service hall exit was removed and a replacement with a lid was placed in the designated smoking	02/17/2023

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	the Maintenance Director and House Keeping Manager agreed cigarette butts were on the ground and smoking took place in non-smoking areas. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		area. d. All cigarette butts outside the kitchen exit were clean up. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. All cigarette butts have been removed and cleaned up, a new metal container with a lid has been provided in the designated smoking area, and all staff have been educated on the policy as well as designated smoking area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of the smoking policy and designated smoking area. The Maintenance Director/Designee will be responsible for completing QAPI	

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			audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing			

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	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 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system	K 0918	**K918 – Electrical Systems – Essential Electric Systems** It is the practice of this facility to ensure emergency generators are allowed a 5 minute cool down period after a load test.	02/17/2023

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	to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director on 02/01/23 between 09:45 a.m. and 12:00 p.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain complete documentation for monthly generator testing for the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 states spark-ignited (Natural Gas) generator sets shall be exercised at least		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The generator load cool down time has been added to the monthly documentation in TELS. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing a generator load test with an allowable cool down time monthly and documenting in TELS. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will be responsible for completing a generator load test with an allowable cool down time monthly and documenting in TELS. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. 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 with the Maintenance Director on 02/01/23 between 09:45 a.m. and 12:00 p.m., documentation for the past 12 months worth of testing did not include the required load percentages. Based on an interview at the time of record review, the Maintenance Director acknowledged the monthly load tests did not include the load percentage on the documentation. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director at the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections for the generator was maintained for 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		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “TELS” weekly for 4 weeks and monthly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	

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	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 records review with the Maintenance Director on 02/01/23 between 09:45 a.m. and 12:00 p.m., documentation for weekly generator inspections only included the charge of the battery in the generator. No other visual aspects of the inspection were documented. Based on an interview at the time of record review, the Maintenance Director acknowledged the findings and agreed the weekly generator inspections were missing inspected items. Findings were discussed with the Assistant Director of Nursing and Maintenance Director at exit conference. . 3.1-19(b) 4. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.			

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	Findings include: During records review with the Maintenance Director on 01/01/23 between 09:45 a.m. and 12:00 p.m., documentation of a four hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director stated a four hour continuous run under load could have been done, but could find no documentation for confirmation. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension			

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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
	cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords were installed properly and used in a safe manor, was not used as permanent wiring, not use for high power draw equipment, and power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice could affect staff on the storage hall. Findings include: Based on observation with the Maintenance Director and House Keeping Manager on 02/01/23 between 11:30 a.m. and 2:30 p.m., The following was observed: a.) In the ADON office a power strip used to power equipment, was not secured, and was dangling from the desk. This condition could put stress on the power cord causing damage to the power cord. b.) A refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Admissions office. c.) A refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in room 216 d.) A Microwave (high power draw equipment) was plugged into and supplied power by a power strip in the Medical Records office. e.) In room 218 a power strip was in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. f.) In room 304 a power strip was in use within 6	K 0920	**K920 – Electrical Equipment – Power Cords and Extensions** It is the practice of this facility to ensure flexible cords are installed properly and used in a safe manor. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A) The power strip used to power equipment in the ADON office was removed. B) The power strip used to power equipment in the admissions office was removed. C) The power strip used to power equipment in room 216 was removed. D) The power strip used to power equipment in medical records office was removed. E) The power strip used to power equipment in room 218 was removed. F) The power strip used to power equipment in the maintenance office was removed. **How other residents having the potential to be affected by the**	02/17/2023

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	155689	A. BUILDING 01 B. WING	02/01/2023

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	feet of a resident care area that did not meet 1363A or 60601-1. g.) Equipment in the Maintenance office was supplied power by an extension cord. Based on interview at the time of observations, the Maintenance Director and House Keeping Manager agreed to the miss use of the aforementioned extension cord and power strips. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months which will include checks for various rooms and office to ensure compliance with extension cords and power strips. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of extension cords and power strip usage. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/17/2023** Compliance Date = 02/17/2023	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with			

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	conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 3 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect up to 21 residents in one smoke compartment. Findings include: Based on observation with the House Keeping Manager on 02/01/23 between 12:00 p.m. and 2:45 p.m., the oxygen storage/transfer room contained liquid oxygen tanks, oxygen cylinders, and other oxygen equipment. Upon testing the door, it would not completely close and latch into the frame. This condition does not separate transfilling of oxygen from portion of a facility wherein patients are housed. Based on interview at the time of observation, the House Keeping Manager agreed that the door would not completely close and latch into the frame.	K 0927	**K927 – Gas Equipment – Transfilling Cylinders** It is the practice of this facility to ensure transfilling of oxygen takes place in oxygen transfilling rooms that are separated from any portion of the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The door to the oxygen transfilling room has been adjusted and fixed to ensure proper close and latch of the frame. **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 by this deficient practice. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months which will include checks of proper closing and latching of doors. **What measures will be put into place or what systemic changes will be made to**	02/17/2023

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	This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 2/17/2023. This in-service will be conducted by the Maintenance Director or Designee and will include a review of egress doors. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool “Life Safety Rounds” 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic**	

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			changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	