| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155376 | A. BUILDING -- B. WING | 04/16/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 04/16/25<br><br>Facility Number: 000336<br>Provider Number: 155376<br>AIM Number: 100290170<br><br>At this Emergency Preparedness survey, Majestic Care of Sheridan was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 80 certified beds. At the time of the survey, the census was 79.<br><br>Quality Review completed on 04/21/25 | E 0000 | | |
| K 0000<br><br>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).<br><br>Survey Date: 04/16/25<br><br>Facility Number: 000336<br>Provider Number: 155376<br>AIM Number: 100290170<br><br>At this Life Safety Code survey, Majestic Care of Sheridan was found not in compliance with | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Abigail Rector | Administrator in Training | 05/03/2025 |

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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| | Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 79 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services which were not sprinklered.<br><br>Quality Review completed on 04/21/25 | | | |
| K 0324 SS=E Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. | K 0324 | 1 The Maintenance Director marked with tape the spot where cooking appliances are to be returned under the kitchen hood extinguishing system after cleaning or maintenance as originally designed.<br>2. All residents have the potential to be affected. No residents affected.<br>3. The Maintenance Director was educated by the Executive Director to ensure all cooking appliances are moved to the | 05/01/2025 |

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| | Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 6 staff in the facility.<br><br>Findings include:<br><br>Based on observations made during a tour of the facility with the Regional Director of Plant Operations and the Administrator-in-Training on 04/16/25 at 1:15 p.m., the six (6) burner electric stove and the flat grill, which was located on the cooking line under the hood in the kitchen, was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on an interview on 04/16/25 at 1:17 p.m., the Regional Director of Plant Operations stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible.<br><br>This item was discussed with the facility Administrator, the Regional Director of Plant Operations, and the Administrator-in-Training at the exit conference on 04/16/25. | | installation place marked by tape to where the cooking appliances were positioned to be underneath the kitchen hood extinguishing system.<br>4. This will be reviewed by the Executive Director/designee upon completion. This information will be sent to QAPI for trending and completion follow-up.<br>5. Completed 4/29/25 | |

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| K 0345 SS=F Bldg. 01 | 3.1-19(b)<br><br>NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:<br>a. Control unit trouble signals<br>b. Remote annunciators<br>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)<br>d. Notification appliances<br>e. Magnetic hold-open devices<br>This deficient practice could affect all occupants in the facility.<br><br>Findings include:<br><br>Based on record review on 04/16/25 at 10:10 a.m. current documentation could not be provided regarding a visual semi-annual fire alarm system inspection. The documentation provided indicated that the last semi-annual visual inspection was completed by the facility vendor on 03/16/24. Based on interview on 04/16/25 at 10:12 a.m., the Regional Director of Plant Operations agreed that a visual semi-annual inspection of the fire-alarm system had not yet been completed adding that he had recently contacted his vendor, and they were scheduled to | K 0345 | 1. The semi-annual fire alarm system inspection for 2025 was completed. Technicians performed testing and provided maintenance on the fire alarm system on 4/17/2025.<br>2. All residents have the potential to be affected. No residents affected.<br>3. The Maintenance Director was educated by the Executive Director to schedule semi-annual fire alarm inspections per TELS calendar.<br>4. This will be reviewed by the Executive Director/designee upon completion, and the Executive Director will review fire alarm system inspections with the Maintenance Director. This information will be sent to QAPI for trending and completion follow-up.<br>5. Completed 4/29/25 | 05/01/2025 |

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| | come out to the facility within the next couple of weeks.<br><br>This item was discussed with the facility Administrator, the Regional Director of Plant Operations, and the Administrator-in-Training at the exit conference on 04/16/25.<br><br>3.1-19(b) | | | |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Based on observation and interview, the facility failed to ensure 1 of 4 sets of 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 as many as 30 residents, 6 staff and 4 visitors within the facility.<br><br>Findings include:<br><br>Based on observations made on 04/16/25 at 1:56 p.m. during a tour of the facility with the Regional Director of Plant Operations and the Administrator-in-Training, the set of barrier doors on the 100 Hall near resident rooms #111 and #112 did not close completely due to air pressure from one side of the doors. There was a six-inch gap between the doors when closed to their fullest when tested on three separate occasions. Based on interview on 04/16/25 at 1:59 p.m., the Regional Director of Plant Operations acknowledged these barrier doors did not close completely due to air pressure holding the North door slightly open adding that he would have the | K 0374 | 1. Maintenance by service provider was provided to the fire door in north hall that was found to not fully latch on inspection. The annual fire door inspection was completed. All fire doors passed the annual fire door inspection.<br>2. 40 residents have the potential to be affected. No residents affected.<br>3. The Maintenance Director was educated by the Executive Director to ensure all fire/barrier doors shut correctly during a fire door inspection and if a defect was found during testing/inspection that the door must be fixed immediately.<br>4. This will be reviewed by the Executive Director/designee upon completion, and TELS will be reviewed monthly for completion of assigned audits. This information will be sent to QAPI for trending and completion follow-up.<br>5. Completed 4/29/25 | 05/01/2025 |

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| | doors adjusted as soon as possible.<br><br>This item was discussed with the facility Administrator, the Regional Director of Plant Operations, and the Administrator-in-Training at the exit conference on 04/16/25.<br><br>3.1-19(b) | | | |
| K 0761 SS=F Bldg. 01 | NFPA 101<br>Maintenance, Inspection & Testing - Doors<br><br>Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the | K 0761 | p="" xml:="" paraid="1264177315" paraeid="{b16be4d5-7e06-4f83-806e-4dffee76a501}{109}" 1.="" annual="" inspection="" and="" testing="" of="" all="" fire="" doors="" are="" completed.="" door="" in="" south="" corridor="" mentioned="" that="" failed="" to="" fully="" self-close="" latch="" into="" frame="" was="" repaired. no="" other="" were="" affected. <="" div<br><br>1. Annual inspection and testing of all fire doors are completed. 2. All residents have the potential to be affected. No residents affected. 3. The Maintenance Director will be educated by the Executive Director that annual inspections and testing of all fire doors must be completed timely. MD was also educated that if a defect was found during testing/inspection, that it must be fixed immediately. 4. The Executive Director/designee upon completion will ensure the | 05/01/2025 |

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| | overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the fully open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Regional Director of Plant Operations on 04/16/25 at 11:36 a.m., a current annual inspection of the fire door assemblies was not available for review with the last documented inspection being completed on 03/26/24. Based on observations during the tour | | inspection is done and documented within TELS. This information will be sent to QAPI for trending and completion follow-up.<br>5. Completed 4/29/25<br>="" p=""> | |

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| | of the facility, there were five fire door assemblies noted in the building that were in occupancy separation walls. Based on interview on 04/16/25 at 11:38 a.m., the Regional Director of Plant Operations stated an annual inspection was not conducted for the fire door assemblies in the last year and stated that he had contacted his vendor, and they were scheduled to come and do the inspection on 04/17/25.<br><br>This item was discussed with the facility Administrator, the Regional Director of Plant Operations, and the Administrator-in-Training at the exit conference on 04/16/25.<br><br>3.1-19(b) | | | |