

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/01/2023	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF DEMING PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/01/23</p> <p>Facility Number: 000249 Provider Number: 155358 AIM Number: 100267640</p> <p>At this Emergency Preparedness survey, Majestic Care of Deming Park was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 86 certified beds. At the time of the survey, the census was 47.</p> <p>Quality Review completed on 05/04/23</p>			E 0000	<p>By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 6-01-23 to the life safety survey completed on 5-1-2023. We respectfully request a paper review and will provide any additional information requested.</p>		
E 0039 SS=C Bldg. --	<p>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)</p> <p>EP Testing Requirements</p> <p>§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).</p> <p>*[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]:</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Pamela

Clevenger

05/25/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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	<p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(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.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(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.</p> <p>*[For Hospices at 418.113(d):]</p>						

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	<p>(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:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>						

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	<p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(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.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual,</p>						

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	<p>facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires</p>						

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	<p>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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the</p>						

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	<p>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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(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</p>						

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	<p>onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(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.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or</p>						

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	<p>functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(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.</p> <p>(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</p>						

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	<p>needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p>			E 0039	<p>It is the practice of this facility to test emergency plan at least twice per year, including unannounced staff drills using the emergency procedures.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. An elopement exercise was completed on 2.22.2023. The maintenance director was unable to locate the</p>		05/16/2023

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E 0041 SS=F Bldg. --	<p>b. A mock disaster drill; or</p> <p>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.</p> <p>(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.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 05/01/23 at 12:30 p.m., there was documentation for a tabletop exercise on December 5, 2022; but no documentation of an additional exercise of choice was available for review. Based on interview at the time of records review, the Maintenance Director stated no other emergency preparedness exercise documentation was available for review.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.</p> <p>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</p>				<p>documentation which had been uploaded to the TELS system at the time of survey. See attachment #1, #2, and #3.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director was on the TELS system and how to retrieve information. All emergency exercises will continue to be completed in a timely manner.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>An audit will be conducted quarterly with the quality assurance committee to assure that the Emergency preparedness plan has conducted exercises to test the emergency plan. Documentation of these drills/exercises will be reviewed by the quality assurance committee.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155358		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/01/2023	
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	<p>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.</p> <p>§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.</p> <p>§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.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>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</p>						

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>power systems operational during the emergency, unless it evacuates.</p> <p>*[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.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p>						

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/01/23 from 10:05 a.m. to 12:52 p.m., documentation of weekly generator testing prior to 03/06/23 was not available for review. Based on an interview at the time of record review, the Maintenance Director confirmed there was no documentation of weekly generator testing prior to 03/06/23 available for review.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p>			E 0041	<p>It is the practice of this facility to monitor the emergency generator on a weekly basis.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice. There are no identified residents.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken: All residents have the potential to be affected but none were identified.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance director reeducated on the deficient practice. The Emergency generators was tested</p>		05/23/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 05/01/23</p> <p>Facility Number: 000249 Provider Number: 155358 AIM Number: 100267640</p> <p>At this Life Safety Code survey, Majestic Care of Deming Park was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101,</p>			K 0000	<p>on 5-14-2023 and will continue to be tested weekly.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be conducted monthly with the quality assurance committee to assure that the Emergency Generator is being tested weekly and documentation is completed at the time of testing. Documentation of these tests will be reviewed by the quality assurance committee. Executive Director to oversee.</p> <p>By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 6-01-23 to the life safety survey completed on 5-1-2023. We respectfully request a paper review and will provide any additional information requested.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 0291 SS=D Bldg. 01	<p>Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the resident sleeping rooms, corridors and in all areas open to the corridor. The facility has a capacity of 86 and had a census of 47 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/04/23</p> <p>NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 3 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, staff and visitors in the facility.</p>			K 0291	<p>It is the responsibility of the facility to ensure battery powered emergency lights are maintained.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.</p> <p>All residents have the potential to be affected but none were</p>		05/23/2023

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/01/23 during a tour of the facility from 12:32 p.m. to 1:46 p.m., the battery operated emergency light at the generator failed to function when its respective test button was pushed three times. Additionally, a battery operated light located in the boiler room failed to function when its respective test button was pushed three times. Based on interview at the time of the observations, the Maintenance Director confirmed that the two battery operated lights failed to function when their respective test button was pushed.</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 3 of 3 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on record review on 05/01/23 from 10:05 a.m. to 12:32 p.m. with the Maintenance Director, there was no monthly or annual Battery Operated</p>				<p>identified. The batteries were replaced in the emergency battery operated light in the generator and also the boiler room. Both lights were added to the monthly and annually battery-operated light check audits.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The ED and maintenance director were reeducated on the deficient practice. The batteries were replaced in the emergency battery operated light in the generator and also the boiler room. Both lights were added to the monthly and annually battery-operated light check audits.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The maintenance director and/or designee will check the battery-operated lights monthly for 30 seconds and annually for 90 minutes. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.</p>		

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K 0321 SS=E Bldg. 01	<p>Emergency Light Testing available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has a battery operated emergency light at the generator but documentation for the monthly test and annual test was not available for review. Based on observations during a tour of the facility with the Maintenance Director on 05/01/23 from 12:32 p.m. to 1:46 p.m., the facility has a battery operated emergency light on the exterior wall by the generator. Additionally, two battery operated emergency lights were located in the boiler room. Based on interview with the Maintenance Director, he stated no monthly or annual testing was available for the two lights in the boiler room.</p> <p>These findings were reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>				<p>="" p=""> ="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p="">="" a.<="" p=""> ="" p=""></p>		
	<p>NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of</p>						

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	<p>hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 2 of over 8 hazardous areas, such as a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 14 residents and 3 staff.</p> <p>Findings include:</p> <p>Based on observations made during a tour of the facility on 05/01/23 at 12:45 p.m. with the Maintenance Director, the corridor door to resident rooms #122 and #125 had been converted to storage. These rooms contained assorted items including: recliners, wooden furniture and dressers, rolls of flooring, and other assorted combustible items creating hazardous areas. Both rooms also measured well over the 50 square feet. The lack of a self-closing device being installed on the corridor doors to each of these converted rooms was confirmed by the Maintenance</p>			K 0321	<p>It is the responsibility of the facility to ensure that corridor doors for hazardous areas, such as storage rooms with combustible supplies are provided with a self-closing device mechanism.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. The supplies that were being stored in the two rooms identified have been cleaned out.</p>		05/31/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 0345 SS=F Bldg. 01	<p>Director at the time of observation.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,</p>				<p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The ED and maintenance director were reeducated on the deficient practice. Full audit of all rooms in the facility were observed and no other doors met criteria for self-closing mechanisms to be added.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or designee will tour bldg monthly for 6 months to assure rooms that must need self-closing mechanisms are properly placed. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.</p>		

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	<p>National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>1. Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device type, address, location and test results indicated:</p> <p>(1) Date</p> <p>(2) Test frequency</p> <p>(3) Name of property</p> <p>(4) Address</p> <p>(5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number</p> <p>(6) Name, address, and representative of approving agency (ies)</p> <p>(7) Designation of the detector(s) tested</p> <p>(8) Functional test of detectors</p> <p>(9)*Functional test of required sequence of operations</p> <p>(10) Check of all smoke detectors</p> <p>(11) Loop resistance for all fixed-temperature, line-type heat detectors</p> <p>(12) Functional test of mass notification system control units</p> <p>(13) Functional test of signal transmission to mass notification systems</p> <p>(14) Functional test of ability of mass notification system to silence fire alarm notification appliances</p>			K 0345	<p>It is the practice of this facility to have an annual testing of all devices.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. A Semi-Annual Fire Alarm Inspection was completed on 9.23.2022, 3.2.2023 and 3.6.2023. On 11.09.2021. a sensitivity test was completed by Koorsen Fire and Security. See Attachments. Koorsen is also scheduled to come back 5-26-2023 to complete another sensitivity test.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director was reeducated getting records from</p>		05/16/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>(15) Tests of intelligibility of mass notification system speakers</p> <p>(16) Other tests as required by the equipment manufacturer's published instructions</p> <p>(17) Other tests as required by the authority having jurisdiction</p> <p>(18) Signatures of tester and approved authority representative</p> <p>(19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place)</p> <p>This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/01/23 at 11:20 a.m. with the Maintenance Director present, the most recent fire alarm system inspection and testing report was dated 03/25/22. There was no documentation of an annual fire alarm inspection since 03/25/22 for review at the time of the survey. Based on interview with the Maintenance Director at the time of record review, he confirmed that a fire alarm inspection report within the last 12 months was not available for review at the time of the survey.</p> <p>2. Based on record review and interview, the facility failed to ensure documentation was available to show that all 89 smoke detectors in the existing portion of the facility were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its</p>				<p>Koorsen Fire and Security as well as keeping documentation on the fire alarm system</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>An audit will be conducted quarterly by the ED to ensure the maintenance director is getting all inspection reports and maintaining records of all inspections. Results will be brought to the quarterly QA meeting to discuss and review. Administrator to monitor.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <p>(1) Calibrated test method.</p> <p>(2) Manufacturer's calibrated sensitivity test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.</p> <p>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/01/23 between 10:05 a.m. and 12:32 p.m. with the Maintenance Director, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24-month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector</p>						

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	<p>sensitivity testing documentation available for review at the time of the survey.</p> <p>3. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC 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:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices <p>This deficient practice could affect all building occupants.</p> <p>Findings include:</p> <p>During record review with the Maintenance Director on 05/01/23 from 10:05 a.m. to 12:32 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The last annual fire alarm inspection available for review was dated 03/25/22. Based on interview at the time of record review, the Maintenance Director agreed that documentation of a visual semi-annual inspection of the fire alarm system was not available for review.</p> <p>These findings were reviewed with the Executive Director and Maintenance Director at the exit conference.</p>						

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K 0353 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>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.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 2 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure</p>		K 0353	<p>It is the practice of this facility to have the sprinkler system tested on a quarterly basis.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the</p>		05/16/2023	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 0355 SS=F Bldg. 01	<p>performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the quarterly sprinkler system inspection records on 05/01/23 at 11:21 a.m. with the Maintenance Director present, there were no quarterly sprinkler system inspection report available for the first (January, February, March) and second (April, May, June) of 2023. The most recent sprinkler inspection report available to review was dated 12/09/22. During an interview at the time of record review, the Maintenance Director agreed there was no written documentation available to show the sprinkler system had been inspected the first and second quarter of 2023 at the time of the survey.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected,</p>				<p>potential to be affected but none were identified. A quarterly sprinkler system inspection was completed on 3.2.2023. Koorsen Fire and Safety will return to facility in June to complete the second quarterly inspection, this was confirmed by the Maintenance Director. See Attachment</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director was reeducated on getting records from Koorsen Fire and Security as well as keeping documentation on the sprinkler system inspections. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>An audit will be conducted quarterly by the ED to ensure the maintenance director is getting all inspection reports and maintaining records of all inspections.</p>		

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	<p>installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 20 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect staff in the garage.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 05/01/23 at 1:10 p.m., an ABC portable fire extinguisher located in the garage was blocked by an eight foot and six foot ladder. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher was blocked and removed the ladders from in front of the fire extinguisher.</p> <p>2. Based on observation and interview, the facility failed to inspect 20 of 20 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items:</p> <ul style="list-style-type: none"> (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, 			K 0355	<p>It is the responsibility of the facility to ensure portable fire extinguishers are not obstructed and are inspected monthly.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.</p> <p>All residents have the potential to be affected but none were identified. The ladder was moved away from blocking the portable fire extinguisher in the garage. All portable fire extinguishers have been inspected and signed off on each of the 20 portable extinguishers.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The ED and maintenance director were reeducated on the deficient practice. The ladder was moved away from blocking the portable fire extinguisher in the garage. All portable fire extinguishers have</p>		05/10/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>cartridge-operated extinguishers, and pump tanks</p> <p>(5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers</p> <p>(6) Indicator for nonrechargeable extinguishers using push to test pressure indicators.</p> <p>Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.</p> <p>Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method.</p> <p>Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 05/01/23 from 12:32 p.m. to 1:46 p.m., the monthly inspection tags on the 20 fire extinguishers located in the facility lacked documentation of a monthly inspections for April 2023. The annual portable fire extinguishers testing was conducted on 03/30/23. Based on interview at the time of observations, the Maintenance Director confirmed that monthly inspections had not been documented on any of the fire extinguishers in the facility.</p> <p>These findings were reviewed with the Executive Director and Maintenance Director at the exit</p>				<p>been inspected and signed off on each of the 20 portable extinguishers.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The maintenance director and/or designee will tour bldg monthly for 6 months to assure rooms that must need self-closing mechanisms are properly placed. The monthly audit will be checked by the ED for 6 months and brought to the monthly QA meeting. Negative findings will be immediately remedied.</p>		

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K 0712 SS=F Bldg. 01	<p>conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 3 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drill reports on 05/01/23 between 10:05 a.m. and 12:32 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period:</p> <p>a. First shift (days) of the first quarter (January, February, March) of 2023</p> <p>b. First shift (days) of the third quarter (July, August, and September) of 2022</p> <p>c. Third shift (overnight) of the fourth quarter (October, November, December) 2022</p>			K 0712	<p>It is the responsibility of this facility to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. A fire drill was conducted on 5/11/23 What measures will be put into place and what systemic changes will be made</p>		05/15/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters.</p> <p>2. Based on record review and interview, the facility failed to ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the facility Fire Drills with the Maintenance Director on 05/01/23 at 10:42 a.m., the fire drill forms for second and third shift of the first quarter of 2023 lacked documentation verifying the transmission of signal. Based on interview at the time of record review, the Maintenance Director confirmed the verification of the of the transmission of the fire alarm signal was not documented for the second and third shift drills in the first quarter of 2023.</p> <p>These findings were reviewed with the Executive Director and Maintenance Director during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>				<p>to ensure that the deficient practice does not recur: The maintenance director was inserviced that fire drills must be held every month on staggering dates and times throughout the month. Every quarter a drill must be conducted on each shift. Drills that occur on the night shift with a silent alarm must be reviewed and alarm sounding the following day. Transmission of a fire alarm signal and simulation of emergency fire conditions must occur and will be documented on fire drill paperwork. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or his designee will conduct monthly fire drills that are on different shifts and staggered throughout the month, quarter and year. The times will also be staggered through a 24 hour period so they all don't fall at the same time on the same shift. Fire drill paperwork will be completed in its entirety. Documentation of the transmission of signal and outcome of simulation. Drills will be brought to the quarterly QA meetings for review and signed by attendees. Administrator to monitor.</p>		

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K 0918 SS=F Bldg. 01	<p>NFPA 101</p> <p>Electrical Systems - Essential Electric Syste</p> <p>Electrical Systems - Essential Electric</p> <p>System Maintenance and Testing</p> <p>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.</p> <p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>1. Based on record review and interview, the facility failed to maintain a complete written record</p>			K 0918	It is the practice of this facility to have a written record of monthly		05/16/2023

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	<p>of monthly generator load testing for 2 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 states spark-ignited (LP Gas) generator sets shall be exercised at least 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.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/01/23 at 12:05 p.m., documentation for monthly generator load testing was provided, but it was incomplete. The monthly load test log had '0' wrote in the load percentage column for the last 12 months. Based on an interview at the time of record review, the Maintenance Director confirmed that the available EPSS load for the last 12 months was not documented on the generator monthly test log sheet.</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 44 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be</p>				<p>generator load testing.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents.</p> <p>How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director was re educated on weekly and monthly maintenance on the generator. Weekly and monthly maintenance was completed on 5/14/2023</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be conducted monthly with the quality assurance committee to assure that the Emergency Generator is being tested weekly monthly and documentation is completed at the</p>		

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K 0923 SS=D Bldg. 01	<p>inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/01/23 from 10:05 a.m. to 12:52 p.m., documentation of weekly generator testing prior to 03/06/23 was not available for review. Based on an interview at the time of record review, the Maintenance Director confirmed there was no documentation of weekly generator testing prior to 03/06/23 available for review.</p> <p>These findings were reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not</p>				time of testing. Documentation of these tests will be reviewed by the quality assurance committee. Executive Director to oversee.		

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	<p>stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 2 of 47 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states</p>	K 0923	<p>It is the responsibility of this facility to ensure that oxygen cylinders are properly secured from falling.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice includes: There are no identified residents How other residents that have the potential to be affected by the</p>		05/10/2023		

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	<p>freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff in the vicinity of the oxygen storage and transfilling room in the garage.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:32 p.m. to 1:46 p.m. on 05/01/23, two of 47 'E' type oxygen cylinders were freestanding on the floor in the oxygen storage and transfilling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Director agreed the two oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>				<p>same defective practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. All staff were inserviced on this deficient practice. The 2 cylinders were properly placed in secured racks. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All staff were inserviced on this deficient practice. The 2 cylinders were properly placed in secured racks. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director and/or his designee will conduct weekly audits of the oxygen room and free standing cylinders for 3 months and then monthly audits for 3 months. All deficient practices will be immediately remedied and results brought to the attention of the ED. Audit results will be shared with the monthly QAPI team.</p>		