STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155247	A. BUILDING -- B. WING	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTHPORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227

(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: 10/24/22 Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060 At this Emergency Preparedness survey, Majestic Care of Southport was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 140 certified beds. At the time of the survey, the census was 87. Quality Review completed on 10/27/22	E 0000		
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 Date: 10/24/22 Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060 At this Life Safety Code survey, Majestic Care of Southport was found not in compliance with	K 0000	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 11-01-22 to the life safety survey completed on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edna Davenport	HFA	11/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155247	A. BUILDING 01 B. WING	10/24/2022

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MAJESTIC CARE OF SOUTHPORT	8549 S MADISON AVE INDIANAPOLIS, IN 46227

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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). The original building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 140 and had a census of 87 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached wooden storage sheds which were each not sprinklered. Quality Review completed on 10/27/22		10-24-2022. We respectfully request a paper review and will provide any additional information requested.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 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			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A 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)			
	Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous areas such as a soiled linen room was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Soiled Utility room near the B Wing nurse's station. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 1:55 p.m. 10/24/22, the corridor door to the Soiled Utility room next to B Wing nurse's station was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested five separate times. When swinging to close, the door bounced off the door jamb on the latching side and failed to latch into the frame.	K 0321	It is the practice of this facility to ensure all hazardous areas are separated from other spaces by smoke resistant partitions and doors. These doors shall be self-closing or equipped with automatic closing mechanisms. **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	11/01/2022

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	Stored in the soiled utility room were eight, 32 gallon containers. Based on interview at the time of observation, the Maintenance Director confirmed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		were identified. The soiled utility room door next to b wings nurses station is equipped with automatic closure. The door was adjusted so it fully latches in door frame when automatic closure is released. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A full audit of the facility found that no other doors that were sheltering hazardous areas were deficient of this practice. **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 audit the entire facility to ensure that all self closing and/or automatic doors are properly latching and meet federal regulations. Door audits will be completed weekly x 4 weeks then monthly. All findings will be immediately remedied and brought to the QA meeting. Administrator to monitor findings	
K 0351 SS=E	NFPA 101 Sprinkler System - Installation			

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Bldg. 01	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 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 maintain the ceiling construction of the facility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 20 residents in B Wing in the vicinity of resident room 153. Findings include: Based on observation with the Maintenance Director on 10/24/22 during a tour of the facility at 1:33 p.m., the storage room located next to resident room 153 had a missing escutcheon.	K 0351	It is the practice of this facility to maintain the ceiling construction of the facility. **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	11/01/2022

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	Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing, stating he didn't realize it had fallen off and would have it replaced. This finding was reviewed with the Administrator and Executive Director at the exit conference. 3.1-19(b)		were identified. The missing escutcheon in storage room next to 153 was replaced. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A full audit of the facility found that no other escutcheons were missing or had any ceiling construction issues. **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 audit the entire facility to ensure the maintenance of the ceiling construction. Weekly walkthrough audits will be completed weekly x 4 weeks then monthly thereafter. All findings will be immediately remedied and brought to the QA meeting. Administrator to monitor findings	
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			

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	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 observation, and interview; the facility failed to ensure all sprinkler heads with physical damage were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect 20 residents	K 0353	It is the practice of this facility to ensure all sprinkler heads with physical damage are replaced in accordance with NFPA 25 and that there is a cabinet located with spare sprinkler heads and a wrench to replace such sprinkler heads when needed. **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. The bent and damaged sprinkler head in the b wing janitor closet was replaced. Cabinet was placed with spare	11/01/2022

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	and staff in hte vicinity of the janitor closet in B Wing. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 1:30 p.m. on 10/24/22, the sprinkler located in the janitor's closet by resident room 149 had a bent and damaged deflector. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned automatic sprinkler had physical damage as it had a bent deflector. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/24/22 from 1:20 p.m. to 2:36 p.m., in the sprinkler riser room,		sprinkler heads in protected spots and wrench. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The bent and damaged sprinkler head in the b wing janitor closet was replaced. A full facility tour was completed and there were no other findings of damaged sprinkler heads. Cabinet was placed with spare sprinkler heads in protected spots and wrench. **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 audit the entire facility to ensure that the all-sprinkler heads are maintained and free of damage. Audit will be conducted monthly x6 months and quarterly thereafter. The cabinet with spare heads and wrench will also be audited monthly for 6 months and quarterly thereafter. All findings will be immediately remedied and brought to the attention of the ED. Findings will be discussed at the quarterly QA meetings.	

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	there were a total of 9 sprinklers sitting loose inside the spare cabinet not in protected slots. Based on interview at the time of the observation, the Maintenance Director confirmed there were spare sprinklers sitting loose in the spare sprinkler cabinet and would have an additional cabinet installed. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
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 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			

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	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 over 30 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observation with the Maintenance Director on 10/24/22 during a tour of the facility 2:10 p.m., the corridor door to resident room 102 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the corridor door would not latch into the door frame, and would work on the door so it would latch. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0363	It is the practice of this facility to ensure all corridor doors have no impediment to closing and latching into the door frame. **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. The resident room door 102 was maintained to ensure that it fully latch into door frame when closed.	11/01/2022

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: A full audit of the facility found that no other doors were deficient of this practice. **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 audit the entire facility to ensure that all fire doors are properly latching and meet federal regulations. Room doors and corridor door audits will be completed weekly x 4 weeks then monthly times 3 months then quarterly times 2 quarters. All findings will be immediately remedied and brought to the QA meeting. Administrator to monitor findings	
K 0000 Bldg. 02	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).	K 0000	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	

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	Survey Date: 10/24/22 Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060 At this Life Safety Code survey, Majestic Care of Southport 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). The 2007 addition was surveyed with Chapter 19 Existing Health Care Occupancies. The 2007 addition to 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 and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 140 and had a census of 87 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached wooden storage sheds which were each not sprinklered. Quality Review completed on 10/27/22		allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-01-22 to the life safety survey completed on 10-24-2022. We respectfully request a paper review and will provide any additional information requested.	