STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155207	A. BUILDING -- B. WING	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/15/22 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Emergency Preparedness survey, Majestic Care of New Haven was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 120 and had a census of 82 at the time of this survey. Quality Review completed on 08/17/22	E 0000	We do not submit this plan of correction as admittance or denial of the alleged incidents. We respectfully request desk review, as we have attempted to include all documentation required as evidence of correction.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	155207	A. BUILDING -- B. WING	08/15/2022

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MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

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	must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient	E 0004	1. The Emergency Preparedness Plan (EPP) was reviewed on 8/24/2022 2. This deficient practice has	09/09/2022

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	practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 08/15/22 at 10:41 a.m., the EEP had a revision date of 2019, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 to review and update the EPP annually by the Senior Executive Director. **4.** Executive Director/designee will review Monthly for 6 months that all required documents are in the EPP binder. This information will be presented to the QAPI committee during the monthly meeting.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 08/15/22 at 10:41 a.m., the EEP had a revision date of 2019, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Policies and Procedures have been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0013	1. The Emergency Preparedness Plan's (EPP) Policy and Procedures was reviewed on 8/24/2022 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 to review and update the EPP Policy and Procedures annually by the Senior Executive Director. **4.** Executive Director/designee will review Monthly for 6 months that all required documents are in the EPP binder. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c),			

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	491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 08/15/22 at 10:41 a.m., the EEP had a revision date of 2019, no other documentation could be found to show the EPP Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Communication Plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	1. The Emergency Preparedness Plan's (EPP) Communication Plan was reviewed on 8/24/2022 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 to review and update the EPP Communication Plan annually by the Senior Executive Director. **4.** Executive Director/designee will review Monthly for 6 months that all required documents are in the EPP binder. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.	E 0036	1. The Emergency Preparedness Plan's (EPP) Training and Testing was reviewed on 8/24/2022 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director	09/09/2022

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	Findings include: Based on records review with the Administrator and Maintenance Director on 08/15/22 at 10:41 a.m., the EEP had a revision date of 2019, no other documentation could be found to show the EPP Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Training and Testing Plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		and Executive Director were educated on 8/24/2022 to review and update the EPP Training and Testing annually by the Senior Executive Director. **4.** Executive Director/designee will review Monthly for 6 months that all required documents are in the EPP binder. This information will be presented to the QAPI committee during the monthly meeting.	
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: 08/15/22 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 At this Life Safety Code survey, Majestic Care of New Haven was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000	We do not submit this plan of correction as admittance or denial of the alleged incidents. We respectfully request desk review, as we have attempted to include all documentation required as evidence of correction.	

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	This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility is partially protected by a Type II EES 60KW diesel powered generator. The facility has a capacity of 120 and had a census of 82 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered which the exception of a detached building housing the emergency generator and used for storage of maintenance equipment. Quality Review completed on 08/17/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 exit gates in the courtyard was readily accessible. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. This deficient practice could affect over 40 residents. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 12:48 p.m., two exits from the building discharged through the courtyard, and the courtyard gate on the exit path was locked with a chain and padlock. Based on interview at the time of observation, the Maintenance Director stated the key to unlock the padlock was carried by the Administrator and Maintenance only, and if they were not in the building the gate could not be unlocked. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	1. The identified padlock was removed and replaced with a combination lock that has the code engraved in it. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 to ensure all gate locks are able to be unlocked during an emergency by the Senior Executive Director. **4.** Executive Director/designee will review monthly with the monthly Fire Drills for 6 months that the identified lock is appropriate and in working order. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet 1 of 8 exit corridors clear width requirement exception per 19.2.3.4(1). LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could 20 residents using the exit outside of the dining room. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 12:30 p.m. and again at 2:30 p.m., in the 8-foot exit corridor by the dining room there was a bed and cart by the exit door reducing the corridor width less than 44 inches. Based on interview at the time of observation, the Maintenance Director stated the bed was to be picked up the next day and agreed there was bed and cart across from each other reducing the required clear width. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0232	1. The identified items limiting the exits egress were removed. 2. This deficient practice has the potential to affect all residents. 3. The management team were educated on 8/24/2022 to ensure all egresses are not blocked or limited by items/equipment by the Senior Executive Director. **4.** Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that egresses are not limited or blocked by items/equipment. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022
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			

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	(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. 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 1 laundry room corridor doors were not obstructed from closing. This deficient practice could affect staff in the service hall. Findings include: Based on observation during a tour of the facility with Maintenance Director on 08/15/22 at 12:10 p.m., the laundry room door was propped open	K 0321	1. The identified laundry corridor door had the item removed that was restricting it from closing. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director, Environmental Supervisor and Executive Director were educated on 8/24/2022 to ensure doors into a corridor that are to automatically	09/09/2022

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	with the inner door. The laundry was equipped with fuel-fired dryers making this a hazardous area. Based on interview at the time of observation, the Maintenance Director agreed the laundry room corridor door was propped open and released the doors. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		close with a fire alarm are not blocked/propped from closing by the Senior Executive Director. **4.** Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that corridor doors are not blocked/propped. This information will be presented to the QAPI committee during the monthly meeting.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff	K 0324	1. The identified cooktop will have a shutoff switch installed in	09/09/2022

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	switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 8 residents in the therapy gym. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 1:25 p.m., there was a new cooktop in the therapy gym that was separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance director stated the shut off switch is in the electrical room in a breaker box, but staff did not have access to the breaker box. This finding was reviewed with the Administrator		the therapy gym. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director, Therapy Director and Executive Director were educated on 8/22/2022 to ensure that a shut off for the cook top must be present for cooktops and its function by the Senior Executive Director. **4.** Executive Director/designee will review monthly for 6 months that the installed shut off is functioning and staff are aware how to use it. This information will be presented to the QAPI committee during the monthly meeting.	

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	and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 2 of 5 sprinklers in the lounge were installed in accordance with NFPA 13, 2010 Edition. Section 8.6.3.4.1 states unless the requirements of 8.6.3.4.2, 8.6.3.4.3, or 8.6.3.4.4 are met, sprinklers shall be spaced not less than 6 ft (1.8 m) on center. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 1:50 p.m., in the resident lounge there were two sprinklers only two feet	K 0353	1. The identified sprinklers will be moved to meet the fire code. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/22/2022 that all sprinklers must be installed in accordance to NFPA 12, 2010 by the Senior Executive Director. **4.** Executive Director/designee will review monthly for 6 months that sprinklers are installed in accordance with NFPA 12, 2010.	09/09/2022

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	apart. Based on interview at the time of the observations, the Maintenance Director measured the distance of the sprinkler heads of two feet distance apart from each other. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		This information will be presented to the QAPI committee during the monthly meeting.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 30 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was	K 0355	1. The identified fire extinguishers received the needed maintenance. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 that all fire extinguishers need to receive needed maintenance in no longer of a period than 1 year by the Senior Executive Director. **4.** Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that all fire extinguishers are serviced at a period of no longer than 1 year. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022

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	performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could 10 residents in the smoke shack and staff using the staff exit. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 12:13 p.m. and 12:45 p.m., the tag on the fire extinguisher in the generator room had an annual inspection date of July 2018, and the fire extinguisher in the smoke shack had an annual inspection date of July 2019. Based on interview at the times of observation, the Maintenance Director agreed both extinguishers were past due for the annual inspections. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=E 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			

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	apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 4 of 15 service corridor doors resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 10/14/21 between 12:40 p.m. and 2:00 p.m., the corridor doors to the south utility room, south linen closet, south pantry, and the north	K 0363	1. The identified doors had the holes filled to prevent smoke and resist fire passage for 20 minutes. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 that all corridor doors need to have no limitations in structure that would allow smoke passage and to ensure they resist fire passage for 20 minutes by the Senior	09/09/2022

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	utility room had two half inch holes that went through the doors. Based on interview at the time of observation, the Maintenance Director stated the holes were due the switching of the door handles. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Executive Director. **4.** Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that all corridor doors will have no limitations in structure that would allow smoke passage and to ensure they resist fire passage of 20 minutes. This information will be presented to the QAPI committee during the monthly meeting.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years.	K 0521	1. The identified fire dampers were inspected per code. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 that all fire dampers need inspected per fire code NFPA 90A by the Senior Executive Director. **4.** Executive Director/designee will review Monthly for 6 months that all required documents are maintained for fire dampers and that they are inspected per code. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022

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	If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 08/15/22 at 10:50 a.m., no documentation was provided to show if the building's smoke/fire damper have ever been inspected. Based on observation with the Maintenance Director between 11:40 a.m. and 2:30 p.m., there were smoke/fire dampers in the duct work and in the air supply vents. Based on interview at the time of records review and observations, the Maintenance Director stated the damper inspection could not be found and did not know when the dampers were inspected. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel			

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	and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 12:15 p.m., the laundry room had fuel-fired dryers with a fresh air intake that was 90% covered with lint and dirt. This condition does not allow fresh air to completely enter the room. Based on an interview at the time of observation, the Maintenance Director stated the intake was covered with lint and would need to be cleaned. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0522	1. The identified lint traps were cleaned to provide intake combustible air. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director, Environmental Service staff, and Executive Director were educated on 8/24/2022 that lint traps must be cleaned to provide clean intake combustible air by the Senior Executive Director. **4.** Executive Director/designee will review daily for 2 weeks, weekly for 4 weeks and monthly for 4 months that all lint traps are clean of lint and dirt. This information will be presented to the QAPI committee during the monthly meeting.	09/09/2022
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:			

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	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure combustible gases were not stored in 1 of 3 smoking areas. This deficient practice could affect 10 residents using the smoking the smoking area Findings include: Based on observation with the Maintenance Director on 08/15/22 at 12:00 p.m., in the resident smoking area by the dining room, there were two propane tanks sitting inside the designated smoking area. Based on interview at the time of observation, the Maintenance Director sated the	K 0741	1. The identified combustibles were removed from the smoke area. 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 that all combustibles are removed from the smoke area by the Senior Executive Director. **4.** Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that all	09/09/2022

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MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

(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
	tanks are used for the grill and agreed they were sitting inside the smoking area. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		combustibles are removed from smoke areas. This information will be presented to the QAPI committee during the monthly meeting.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 #1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring.	K 0920	1. The identified extension cords were removed or replaced with medical grade cords.	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING 01 B. WING	08/15/2022

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	NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 25 residents in two smoke compartments Findings include: Based on observation with the Maintenance Director on 08/15/22 at 11:50 a.m. and at 2:05 p.m., refrigerators were plugged into and supplied power by extension cords in the Payroll office and in the Case Manager office. Based on interview at the time of observation, the Maintenance Director acknowledged extension cords were in use and did remove the extension cords. #2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observation with the Maintenance Director on 08/15/22 at 12:00 p.m., a power-strip in room 402 was in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power-strip was in use in a resident care area and did not meet 1363A or 60601-1. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director and Executive Director were educated on 8/24/2022 that flexible extension cords are to be used in place of fixed wiring and that extension cords are not to be within six feet of a resident care area without being medical grade by the Senior Executive Director. **4.** Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that all extension cords in offices and residents' rooms are used in accordance with fire code. This information will be presented to the QAPI committee during the monthly meeting.	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect up to 21 residents in one smoke compartment. Findings include:	K 0927	1. The identified oxygen transfer room was cleaned to permit staff to fill oxygen in the room 2. This deficient practice has the potential to affect all residents. 3. The Maintenance Director, Director of Nursing and Executive Director were educated on 8/24/2022 that oxygen transfer must occur inside the oxygen room, and equipment stored to permit this by the Senior Executive Director. 4. Executive Director/designee will review weekly, for 4 weeks and then monthly for 5 months that oxygen transfer must occur inside the oxygen room, and equipment stored to permit it. This information will be presented to the QAPI committee during the monthly meeting	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Based on observation with the Maintenance Director on 08/15/22 at 12:05 p.m., the oxygen storage/transfer room contained liquid oxygen tanks, oxygen cylinders, and other oxygen supplies completely filling the room. This condition dose not leave enough room for a person transfilling oxygen inside the room with the door closed. Based on interview at the time of observation, the Maintenance Director stated staff can not fit inside the room and transfilling oxygen took place in the service hall. At the time of exit the DON stated there is not room to fill in the transfer room and for now staff will transfill oxygen outside until a new procedure is created. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			