STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155359	A. BUILDING -- B. WING	11/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

(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: 11/29/21 Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980 At this Emergency Preparedness survey, Majestic Care of Fort Wayne 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 66 and had a census of 60 at the time of this survey. Quality Review completed on 11/30/21	E 0000		
E 0004 SS=C 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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	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	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/10/2021

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	practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:41 a.m., no documentation was provided to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated there was no documentation to show the EEP was reviewed and updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**practice;** On 12/10/21 the Maintenance Director/designee updated the EPP and the IDT reviewed it for accuracy and signed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The EPP was audited to ensure all applicable preventative maintenance items and emergency preparedness plans have been completed on 12/10/21 by the Executive Director/Designee. **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 educated on the need for and utilization of the EPP by the Executive Director/Designee on 12/8/21. The EPP will be reviewed weekly by the Executive Director/Designee to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool EPP will be completed	

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			weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment.			

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	* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk			

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	assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:45 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on interview at the time of record review, the Administrator stated a risk assessment utilizing an all-hazards approach could not be found. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0006	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Maintenance Director/designee updated the EPP to ensure that it included a facility-based and community-based risk assessment utilizing an all-hazards approach. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The EPP was audited to ensure that there is a facility-based and community-based risk assessment utilizing an all-hazards approach on 12/10/21 by the Executive Director/Designee. **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 educated on the	12/10/2021

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			need for and utilization of the EPP by the Executive Director/Designee on 12/8/21. The EPP will be reviewed weekly by the Executive Director/Designee to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool EPP will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
E 0013 SS=C 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			

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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. *[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			

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	and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) policies and procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:41 a.m., no documentation was provided to show the EPP policies and procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator stated there was no documentation to show the EEP policies and procedures were reviewed and updated within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0013	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Maintenance Director/designee updated the EPP to ensure that it included policies and procedures regarding the EPP and that they were reviewed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The EPP was audited to ensure that it includes policies and procedures regarding the EPP and that they were reviewed on 12/10/21 by the Executive	12/10/2021

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			Director/Designee. **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 educated on the need for and utilization of the EPP by the Executive Director/Designee on 12/8/21. The EPP will be reviewed weekly by the Executive Director/Designee to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool EPP will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)			

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	(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which			

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	includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents	E 0018	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/10/2021

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	in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants, Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:51 a.m., documentation of a system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency was not provided. Based on interview at the time of record review, the Administrator stated a staff and resident tracking policy could not be found. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.		**practice;** On 12/10/21 the Maintenance Director/designee updated the EPP to ensure that it included documentation of a system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The EPP was audited to ensure that it includes documentation of a system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency. on 12/10/21 by the Executive Director/Designee. **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 educated on the need for and utilization of the EPP by the Executive Director/Designee on 12/10/21. The EPP will be reviewed weekly by the Executive Director/Designee to ensure compliance. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; QAPI tool EPP will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
E 0020 SS=C Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the			

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	[facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes	E 0020	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/10/2021

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	consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:52 a.m., documentation of a system to evacuate from the facility during an emergency was not provided. Based on interview at the time of record review, the Administrator stated a facility evacuation policy could not be found. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.		**practice;** The policy and procedure addressing safe evacuation were added to the EOP on 12/10/21. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the deficient practice. The Executive Director was educated on where to locate the Evacuation policy and procedure by the Regional Vice President of Operations on 12/10/21. These documents were added to the Emergency Operations Manual on 12/10/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Emergency Operations Plan will be reviewed annually at a minimum to ensure all required policies, procedures and documentation are present. All staff was educated on the EOP by the Executive Director on 12/10/21. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool EPP will be completed	

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			weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
E 0022 SS=C Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures.			

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	(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:53 a.m., documentation of a system to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency was not provided. Based on interview at the time of record review, the Administrator stated a facility shelter in place policy could not be found. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0022	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The policy addressing a system to shelter in place for patients, staff and volunteers who remain in the facility during an emergency was added to the EOP on 12/10/21. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the deficient practice. The Executive Director was educated on where to locate the Shelter in Place policy and procedure by the Regional Vice President of Operations on 12/10/21. These documents were added to the Emergency Operations Manual on 12/10/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	12/10/2021

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			The Emergency Operations Plan will be reviewed annually at a minimum to ensure all required policies, procedures and documentation are present. All staff was educated on the EOP by the Executive Director on 12/10/21 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The EOP will be reviewed annually in the QAPI meeting and updated as needed. All staff will be educated upon hire and at a minimum annually on the EOP.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §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	E 0029	**What corrective action(s) will**	12/10/2021

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	failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:55 a.m., the provided EPP did not include a written communication plan. Based on interview at the time of record review, the Administrator stated the facility communication plan could not be found. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.		**be accomplished for those residents found to have been affected by the deficient practice;** Emergency preparedness policies and procedures were updated with the written Communication Plan on 12/10/21. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the deficient practice. The Executive Director was educated on where to locate the written Communication Plan by the Regional Vice President of Operations on 12/10/21. These documents were added to the Emergency Operations Manual on 12/10/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Emergency Operations Plan will be reviewed annually at a minimum to ensure all required policies, procedures and documentation are present. All staff was educated on the EOP by the Executive Director on 12/10/21. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place; The EOP will be reviewed annually in the QAPI meeting and updated as needed. All staff will be educated upon hire and at a minimum annually on the EOP.	
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.			

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	*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least 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			

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	orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 10:55 a.m., the provided EPP did not include a written training and testing program. Based on interview at the time of record review, the Administrator stated the facility training and testing program documentation could not be found. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0036	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Emergency preparedness policies and procedures were updated to include information in accordance with 42 CFR 483.73 (b) (3). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the deficient practice. The Executive Director was educated on where to locate the written training and testing policy and procedure by the Regional Vice President of Operations on 12/10/21. These documents were added to the Emergency Operations Manual on 12/10/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Emergency Operations Plan will be reviewed annually at a minimum to ensure all required policies, procedures and documentation are present. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	12/10/2021

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			recur, i.e., what quality assurance program will be put into place; The training, testing and orientation program will be evaluated and updated at a minimum of annually . Any updates will be brought to the monthly QAPI meeting and education will be provided to all staff.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new			

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	structure is built or when an existing structure or building is renovated. 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. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to			

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	155359	A. BUILDING -- B. WING	11/29/2021

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MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

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	announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on observation and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include:	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The generator was inspected and repaired on 12/10/21 and was found to power the emergency lighting required by LSC and	12/10/2021

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	Based on observation with the Maintenance Director on 11/29/21 at 12:41 p.m., the generator systems were not properly functioning and would not power the emergency lighting required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director state the generator was not properly working when tested. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.		NFPA 110. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the deficient practice. The Maintenance Director was educated on ensuring the generator is functioning properly at all times by the Executive Director/Designee on 12/10/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Any issue with the generator not powering the emergency lighting will be brought to the attention of the Executive Director and will be addressed immediately through the appropriate vendor. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The generator will be inspected weekly and test run for 30 minutes monthly. The Maintenance Director will ensure all emergency lighting is powered at that time. This will be documented in the TELS system and verified by the Executive Director during the monthly QAPI meeting.	

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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: 11/29/21 Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980 At this Life Safety Code survey, Majestic Care of Fort Wayne 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. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 66 and had a census of 60 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies Quality Review completed on 11/30/21	K 0000		

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 25 residents in the east hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 Between 10:00 a.m. and 2:00 p.m., in the east resident hall there were three wooden pallets of supplies protruding into the corridor about three feet. Based on an interview at the time of observations, the Maintenance Director agreed there were wooden pallets obstructing the pass of egress in the east hall. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0211	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Maintenance Director/designee moved the 3 pallets out of the east residents hall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Executive Director/designee rounded in all areas of the facility on 12/8/21 to ensure that there were no items obstructing the pass of egress in the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	12/10/2021

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			All staff were educated on the need to keep all items out of the means of egress by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0222 SS=F 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			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors 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			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 5 of 5 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 between 11:00 a.m. and 1:13 p.m., all exit doors were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the four digit codes were not posted by the keypads. This condition could delay someone from exiting the building during an emergency. Based on interview at the time of observation, the Maintenance Director agreed codes were not posted at the keypads. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Maintenance Director/designee placed all of the codes near the keypads to ensure means of egress. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Executive Director/designee audited all doors requiring a means of egress to ensure that the codes were posted near the keypads to ensure means of egress. **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 educated on the need to keep the posted codes near the keypads on doors	12/10/2021

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			requiring means of egress and the location of those codes by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width	K 0232	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	12/10/2021

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	shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 5 residents in front hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 11:51 a.m., two chairs in the main entrance corridor extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Maintenance Director agreed		On 12/10/21 the Maintenance Director/designee moved the 2 chairs to another location. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Executive Director/designee rounded in all areas of the facility on 12/8/21 to ensure that there were no items obstructing the pass of egress in the facility. **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 educated on the need to keep all items out of the means of egress unless affixed to the floor or the wall by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks,	

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	the chairs were not securely attached to the floor or to the wall when tested. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. 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 were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be	K 0324	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Executive Director/designee in-serviced all	12/10/2021

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	reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 11:41 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked how to activate the hood suppression system if there was a grease fire underneath the hood. The Cook stated she did not know how to activate the suppression system or the location of pull station to activate the suppression system. The Maintenance Director acknowledged the Cook's response and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		kitchen staff as to how to utilize a UL 300 hood system and K-class fire extinguisher. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Executive Director/designee rounded in all areas of the kitchen on 12/10/21 to ensure that there were no further items that the kitchen staff were unaware of how to utilize in case of an emergency. **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 educated on how to properly utilize the UL 300 hood system and K-class fire extinguisher by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks,	

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			bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 11/29/21 at 9:35 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the	K 0346	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Maintenance Director/designee ensured that the fire watch plan in the EPP included contacting the Indiana Department of Health via the IDOH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. **How other residents having the potential to be affected by the**	12/10/2021

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MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

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	Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Executive Director/designee audited the EPP on 12/10/21 in order to ensure that the fire watch plan included contacting the Indiana Department of Health via the IDOH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. **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 educated on the need to contact the Indiana Department of Health via the IDOH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov in the case of fire watch by the Executive Director/Designee on 12/10/21. This will be audited weekly by the ED/designee in order to ensure compliance.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; QAPI tool EPP will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment	K 0354	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Maintenance	12/10/2021

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	procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and Administrator on 11/29/21 at 9:35 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Director/designee ensured that the fire watch plan in the EPP included the policy as to the procedures of for when the sprinkler system is down for more than 10 hours and the need to contact the Indiana Department of Health via the IDOH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Executive Director/designee audited the EPP on 12/10/21 in order to ensure that the fire watch plan included EPP included the policy as to the procedures for when the sprinkler system is down for more than 10 hours and contacting the Indiana Department of Health via the IDOH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. **What measures will be put into**	

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	3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on the need for the EPP to included the policy as to the procedures for when the sprinkler system is down for more than 10 hours and to contact the Indiana Department of Health via the IDOH Gateway Link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov in the case of fire watch by the Executive Director/Designee on 12/10/21. This will be audited weekly by the ED/designee in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool EPP will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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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 #1. Based on observation and interview, the facility failed to ensure 1 of 15 portable fire extinguishers were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 12:11 p.m., an ABC portable fire extinguisher was sitting on a shelf unsecured in the nurse's station. Based on interview at the time of observation, the Maintenance Director stated the extinguisher was from the dining room and need to be remounted. #2. Based on observation and interview, the facility failed to ensure 1 of 15 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	K 0355	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Executive Director/designee ensured that the ABC fire extinguisher in the nurses station was properly secured to the wall in the dining room and that all 15 of the portable fire extinguishers were given maintenance within a years time. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The IDT/designees completed Majestic Rounds in all areas on 12/10/21 to ensure that all portable fire extinguishers were secured properly to the wall and that they received their annual inspection within the past year. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	12/10/2021

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	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 performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could 2 residents in the beauty shop. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 12:02 p.m., the tag on the fire extinguisher in the therapy gym had an annual inspection date of July 2020 while all other fire extinguishers in the building had an inspection date of July 2021. Based on interview at the times of observation, the Maintenance Director stated it is most like that the extinguisher in beauty shop was missed during the annual inspection. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**practice does not recur;** All staff were educated on how ensure that the portable fire extinguishers were properly secured to the wall and where to audit to ensure that they were serviced in the past year by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0521 SS=E	NFPA 101 HVAC			

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Bldg. 01	HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 4 of 79 fire dampers in the facility were repaired after inspection in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. 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 50 residents in three smoke compartments. Findings include: Based on records review with the Administrator and the Maintenance Director on 11/29/21 at 9:41 a.m., the Fire Damper Inspection dated 05/08/19	K 0521	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Executive Director/designee ensured that the 4 Fire Dampers were Inspected and in working order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Maintenance Director/designee inspected all fire dampers throughout the facility on 12/10/21 to ensure that they were in working order. **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 and Designee were educated on the need for all Fire Dampers to work and to have documented inspections once every 4 years by the Executive Director/Designee on 12/10/21. The Maintenance	12/10/2021

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	indicated four fire dampers needed repairs or replaced. No other documentation was provided to show if the four dampers were fixed or re-inspected. Based on interview at the time of records review, the Maintenance Director confirmed there were dampers on the inspection form that needed repair and stated there no other documentation could be found to show if the repairs were made. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Director/designee will audit weekly for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Preventative Maintenance will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.			

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	(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 20 residents in the courtyard. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 12:41 p.m., in the courtyard resident smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observation, the Maintenance Director agree there were cigarette butts on the ground in the resident smoking area. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Executive Director/designee ensured that the smoking area was equipped with a self closing cigarette butt disposal container. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The IDT/designees completed Majestic Rounds in all areas on 12/10/21 to ensure that the self closing container was in place and that there were no cigarette butts on the ground in the smoking area. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	12/10/2021

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			practice does not recur; All staff were educated on how properly dispose of cigarette butts in the residents smoking area by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 2 equipment branch electrical panels had clear access and working space.	K 0911	What corrective action(s) will be accomplished for those residents found to have been affected by the	12/10/2021

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MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

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	NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A)(1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A) (1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could 30 residents in one hall Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 10:48 a.m., two equipment electrical panels in the laundry room were blocked from access and did not have a clear workspace due to a bin and barrel stored in front of the panels. Based on interview at the time of the observations, the Administrator agreed items were stored within the		deficient practice; On 12/10/21 the Executive Director/designee ensured that the bin and barrel in the laundry room were removed from blocking the electrical panels. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The IDT/designees completed Majestic Rounds in all areas on 12/10/21 to ensure that there were no items blocking electrical panels. **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 educated on the importance of keeping items out of obstruction of all electrical panels by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks,	

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	155359	A. BUILDING 01 B. WING	11/29/2021

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	working space in front of the electrical panels. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on record review and interview, the facility failed ensure 1 of 1 emergency generator annunciator panels was hard-wired to normal power to indicate alarm conditions of the generator in accordance with NFPA 99 6.4.1.1.17. This deficient practice could affect all occupants. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 12:11 p.m., the generator annunciator panel showed there was no power to the panel leaving the status of the generator unknown. Based on interview with the Maintenance Director and Generator Technician form Safe Care at 1:10 p.m., the Generator Technician stated the generator had	K 0916	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 11/29/21 the Executive Director/designee ensured that the charger to the generator battery was replaced, leaving the generator's annunciator panel in working condition. On 12/10/21 the Executive Director/designee ensured that the generator's annunciator panel was hard-wired to normal power to indicate alarm conditions. **How other residents having the**	12/10/2021

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	a bad charger leaving the battery dead, therefore not powering the annunciator panel. When the Generator Technician was asked if the annunciator panel was connected to normal power, he stated no; the annunciator panel is only powered by the battery from the generator. The Generator Technician did replace the charger and battery leaving the annunciator panel in working condition. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Maintenance Director/designee completed a load test on the generator on 12/10/21 to ensure that it is in working order. **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 and Designee were educated on the need to complete and document the load test weekly and to report any issues with the generator immediately to the Executive Director by the Executive Director/Designee on 12/10/21. The Maintenance Director/designee will audit weekly for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Preventative Maintenance will be completed weekly X 4 weeks, bi-monthly X 2 and monthly thereafter by Executive Director/Designee If 100% threshold is not achieved an	

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			action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design			

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	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators were properly maintained and in working condition. This deficient practice could affect all occupants. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21 at 12:11 p.m., the generator annunciator panel showed there was no power to the panel leaving the status of the generator unknown. Upon inspection of the generator, the generator would not start due to a dead battery. Based on interview with the Maintenance Director and Generator Technician from the facility's contracted generator service provider at 1:10 p.m., the Generator Technician stated the generator had a bad charger and would not charge the battery. The Generator Technician replaced the charger and battery leaving the generator in working condition. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 11/29/21 the Executive Director/designee ensured that the charger to the generator battery was replaced, leaving the generator's annunciator panel in working condition. On 12/10/21 the Executive Director/designee ensured that the generator's annunciator panel was hard-wired to normal power to indicate alarm conditions. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The Maintenance Director/designee completed a load test on the generator on 12/10/21 to ensure that it is in working order. **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 and Designee were educated on the need to complete and document	12/10/2021

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			the load test weekly and to report any issues with the generator immediately to the Executive Director by the Executive Director/Designee on 12/10/21. The Maintenance Director/designee will audit weekly for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Preventative Maintenance will be completed weekly X 4 weeks, bi-monthly X 2 and monthly threreafter by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. 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			

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	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 Based on observation and interview, the facility failed to ensure 3 of 3 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 30 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 11/29/21 between 11:50 a.m. and 1:00 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in DON Office, Business Office, and the Medication Room. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 12/10/21 the Executive Director/designee ensured that the power strips in the DON office, Business Office and Medication Room were removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. The IDT/designees completed Majestic Rounds in all areas on 12/10/21 to ensure that there were no items with a high current draw plugged into power strips. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	12/10/2021

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	3.1-19(b)		**practice does not recur;** All staff were educated on the importance of keeping items with a high current draw from being plugged into power strips by the Executive Director/Designee on 12/10/21. Majestic Rounds Ambassadors will round daily in order to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Majestic Rounds will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	